S. HRG. 103-256

HEALTH CARE FRAUD AS IT AFFECTS THE AGING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

RACINE, WISCONSIN

AUGUST 13, 1993

Serial No. 103-11

Printed for the use of the Special Committee on Aging

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HEALTH CARE FRAUD AS IT AFFECTS THE AGING

FRIDAY, AUGUST 13, 1993

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Racine, Wisconsin

The Committee met, pursuant to notice, at 9:30 a.m., at Gateway Technical College, Racine, Wisconsin, Hon. Herb Kohl (Acting Chairman of the Committee), presiding.

Present: Senator Kohl.

OPENING STATEMENT OF SENATOR HERB KOHL, ACTING CHAIRMAN

Senator KOHL. Good morning. Good morning, ladies and gentlemen.

I'm glad to have you all here today, and I hope that we will have a very important and informative hearing this morning. You know, if you ask most Americans what they feel is the most important issue facing our country and our Congress, health care is near the top of anybody's list. Indeed we all know the President and the First Lady are working very hard toward a national health care plan, the details of which we expect will be released sometime early this fall. Health care reform is certain to be one of the most debated issues of our time, and we know it will be indeed one of the most controversial.

No matter what is decided in the health care reform there is one illness in our health care system that we cannot ignore. And this illness is fraud. It is literally bleeding our health care system into critical condition. Late last year the General Accounting Office released a very disturbing report. The General Accounting Office estimates that 10 percent of the dollars that we spend on health care in America are being stolen through waste, fraud, and abuse.

This year it is estimated that $900 billion will be spent on medical care in our country. That means that $90 billion, or 10 percent, will be lost through illegal or unethical activities that rob us of our precious health care dollars. We have to stop this bleeding and I hope that today's hearing will be a step in the right direction.

We will hear today from a variety of witnesses who will tell us how this fraud is occurring and how we might put a stop to it. Unfortunately, health care fraud takes many forms, but ultimately we are all its victims. Sometimes it comes from dishonest medical professionals who bill people for medical services that they don't need, or even for medical services that were never rendered. At other times this fraud involves grossly overcharging people who seek and

need medical help. And at its worst, some health care fraud schemes target the desperate and the dying, promising bogus and medically unproven cures for everything from cancer to AIDS, often at outrageous prices. In fact, there are cases currently under investigation where people in need of medical help were physically harmed or even died from using these so-called medical cures.

These health care schemes prey upon everyone in our society, but sadly one of their favorite targets is the Nation's growing senior population. The aging are targeted for a variety of reasons. Seniors are certainly big consumers of health care services and so they are often insured through public or private insurance programs. The aging can be particularly vulnerable because they often seek relief for chronic medical conditions in hopes of living out their final years in greater comfort. It is no wonder that slick "snake-oil salesmen" appear on the scene with unproven potions to relieve the pain of arthritis or to reverse the effects of Alzheimer's disease. We need to put these charlatans out of business, and if necessary, put them in jail.

It is important to point out that health care consumers are not the only victims here. Many of these health care fraud schemes are set up to rip off insurance companies, whether they be private companies or Government-sponsored programs like Medicare and Medicaid. Patients are offered so-called "free" medical tests with the promise of "don't worry, you don't have to pay a dime. It will all be billed to your insurance." Because of this, patients may never know that insurance companies might be grossly overbilled for tests and procedures that were never performed, or might not have been medically necessary. Ultimately, we are all victims, even if we are perfectly healthy, because fraud only drives up the costs of medical care and insurance for everybody.

So we know that fraud exists. The question is what should we do about it? When I return to Washington I intend to take three steps.

First, I plan to review a number of health care fraud bills currently being considered in the House of Representatives with an eye toward sponsoring similar legislation in the Senate. It is clear that we need tougher criminal sanctions against those who rob our health care system.

Second, I will ask Health and Human Services Director Donna Shalala to review proposed budget cuts in the investigations unit of her agency. As it stands now, this department may lose over 70 investigators and may close 10 field offices, including one in our own State in Madison.

I am concerned about possible cutbacks on investigations at a time when health care fraud is drastically increasing. According to the Office of Inspector General, it recovers $63 in fraud losses for every dollar that we spend funding them. This certainly sounds like the proper kind of an investment.

And finally, I will ask the Federal Trade Commission to review possible deceptive practices in medical advertising. As we will hear today, some citizens are being lured by promises of so-called "free" medical services when, in fact, these services are being billed to Medicare and others.

Stopping health care fraud is by no means the total answer to our Nation's health care crisis, but it is an important step that we cannot afford to overlook. We need to enlist a broad spectrum of people to solve this problem, and that is why today we will hear from Government leaders and investigators, private insurance company officials, and advocates for an aging population who so often are the targets of these health care fraud schemes.

Again, I want to thank all of you for being here for this important discussion and we look forward to hearing the testimony.

I am delighted to read just a brief part of testimony from Senator Russell Feingold, who is not able to be here today, but I will put his full testimony in the record.

He writes that, "I am delighted to join Senator Kohl in welcoming each of you to this morning's hearing of the Senate Special Committee on Aging. Because of previously scheduled listening sessions throughout Wisconsin, I am unable to attend this morning's field hearing. I'm particularly disappointed because some of the most innovative aging and long-term care programs initiated in Wisconsin have come from this part of the State.

I'm particularly pleased to serve with Senator Kohl on the Special Committee on Aging and am delighted that Wisconsin has both of its Senators on this important committee. Under the leadership of Chairman David Pryor of Arkansas, this committee has held a series of excellent hearings over the past 7 months. These hearings have covered a wide variety of critical issues and have also featured a strong emphasis on public education."

[The prepared statement of Senator Feingold follows:]

PREPARED STATEMENT FROM SENATOR RUSSELL D. FEINGOLD

I am delighted to join Senator Kohl in welcoming each of you to this morning's hearing of the Senate Special Committee on Aging. Because of previously scheduled listening sessions in Trempealeau, Dunn, and La Crosse Counties, I am unable to attend this morning's field hearing, a particular disappointment for me as some of the most innovative aging and long-term care programs initiated in Wisconsin have come from this part of the State.

I am particularly pleased to serve with Senator Kohl on the Special Committee on Aging, and am delighted that Wisconsin has both of its Senators on this important committee. Under the leadership of Chairman David Pryor of Arkansas, the Committee has held a series of excellent hearings over the past seven months. Those hearings have covered a wide variety of critical issues and have also featured a strong emphasis on public education.

Senator Pryor is not alone in identifying and addressing important aging issues. Senator Kohl has taken a lead role in addressing the issue of health care fraud as it affects seniors, and deserves enormous credit for that effort. It was his pioneering work in the area of Medigap insurance abuses, which featured a field hearing in Wisconsin just like this one, that led to many of the reforms to Medicare supplemental insurance we gained at both the State and national level.

I share Senator Kohl's concerns in the area of health care fraud, and am particularly interested in problems associated with potentially unnecessary cataract surgery. I look forward to reading the testimony that will be given at today's hearing, and in working with Senator Kohl, Attorney General Doyle, and others in helping to identify and combat fraudulent health care practices.

The work that will flow from today's hearing may well play an important role in keeping health care costs to seniors down, and should be considered as part of First Lady Hillary Rodham Clinton's larger effort to reform the health care system.

Again, I thank each of you for participating in this morning's hearing.

Senator KOHL. I would like also to recognize Jeri Gabrielson, who is from Senator Feingold's staff, who's here today, and we're delighted to have you with us, Jeri.

So now we come to our first witness, and I would like to introduce that witness to you. We're talking about the Honorable James Doyle, Jr., who is the Attorney General for the State of Wisconsin. His office oversees the State's Medical Fraud Task Force, as well as the Division of Consumer Protection.

In addition to his many duties here in the State, Mr. Doyle is also vice chairman of the Consumer Protection Committee for the National Association of Attorneys General. That group is based in Washington, DC, and they have been very involved in the area of health care fraud.

Now, originally Attorney General Doyle was going to be our second panel this morning, but since he has to catch a flight to another part of the State, we will let him testify now and then we will proceed with our other witnesses.

Mr. Doyle, your written testimony has been received and will be entered without objection into the official hearing record, and we would love to hear what you have to say this morning.

STATEMENT OF HON. JAMES E. DOYLE, ATTORNEY GENERAL, STATE OF WISCONSIN

Mr. DOYLE. Thank you, Senator Kohl. I appreciate your taking me out of order. I do have another commitment and I appreciate the consideration that you have shown.

I also want to say how much I appreciate your conducting this hearing in Wisconsin. This is an issue that in both my roles with the Medicaid Fraud Task Force in Wisconsin and consumer protection that we work with all the time. Your drawing attention to this in Wisconsin is extremely important. Our Consumer Protection Office records complaints, mediates problems for consumers, and investigates and prosecutes violations of Wisconsin's numerous consumer protection laws. Increasingly, we have been seeing a large number of unscrupulous offers being made by direct mail firms and telemarketers that try to take money away from older Wisconsin residents and offer them medical products of dubious value. Because our time is limited, I will only mention a few of the kind of health care scams we are seeing directed against elderly victims. One of the biggest problems we see is in the area of prize and sweepstakes promotions targeted against older consumers. The contests promise valuable prizes, but there's almost always a catch. Usually the older consumer is asked to pay money or buy merchandise in order to claim the prize. Often the products being sold at such promotions are vitamins or other health care products. These are some of the vitamin and nutrition products that Wisconsin consumers have purchased in order to win a prize. They look very inviting, don't they? Sometimes the products are normal vitamins that you can pay much less money for in a retail store. For example, older consumers purchased a 6-month supply of Great Start vitamins for $299 in order to win a Cadillac, $5,000 in cash, a trip for two to Hawaii, an organ, or a steam sauna. The prizes won were not worth the cost of the vitamins, and for only $40 you could have purchased the same concentration of vitamins in a store.

Last year we sued Gerovicap Pharmaceutical Corp. These are the kind of names they use. Gerovicap Pharmaceutical Corp. of Las Vegas—sounds like a very respectable business. Customers had to

buy $500 worth of vitamins in order to claim a new Cadillac, $40,000 in cash, 2,000 ounces of silver, or a cocktail ring. Virtually all of the customers got a cheap cocktail ring for their purchase of these vitamins for $500. That promotion was one that was particularly targeted at elderly citizens. Such prize offers are scams which try to take large sums of money away from older consumers. We have received reports of a 73-year-old woman, living on a fixed income of $530 a month, who paid nearly $750 for vitamins. In another instance, a retired man with epilepsy paid almost $1,300 for vitamins with the understanding that he could win a car, a diamond watch, money, or a color TV.

In addition to losing money, we are also worried that older people who purchase vitamin products through telemarketing promotions may use the vitamins without appropriate medical guidance or take excessive or unsafe amounts.

We are also concerned that elderly consumers with limited incomes, who have spent a lot of money on vitamins, will forego the needed treatment that they must have from medical professionals.

We have also seen efforts to provide anti-aging formulas to senior citizens. My office has been cooperating with the Food and Drug Administration's review of Vita Industries. The full page newspaper ads that we have displayed here tell us that American scientists have improved the same anti-aging formula used by movie stars such as Elizabeth Taylor, who is a frequent visitor at a famous Romanian clinic. These are the kinds of ads that are being sent to individuals, often with this handwritten note. This one appears to be a handwritten, stick-on note that, in this case, says, "George, try it. This works. R." The suggestion, of course, is that some friend, "R," has personally used this and is endorsing it and sending it on to George. These kind of stick-on, personalized notes are increasingly becoming the device that is being used to suggest that it works.

We have also had complaints about television and newspaper ads for specially tinted glasses with pin holes that look like this, sort of like 3D glasses, which claim to help people with cataracts, double vision, and astigmatism. If you pay $40 for the glasses, you usually only end up seeing red. Eye doctors who have examined the glasses say they are useless. We have helped people get their money back, but such offers pose problems for State authorities. Our concern also with such offers as these glasses for cataracts is that older citizens who, in fact, have cataract or other eye problems forego getting the needed medical attention because they think that they somehow are doing something with such devices.

Often the same promotions market nationally under different names from companies at different addresses. And, when we are successful in stopping solicitations in Wisconsin, the same offers can target victims in other States. My office will continue to work with the national consumer agencies like the FDA and the FTC and with the U.S. Postal authorities to try to stop such marketing efforts. However, I fully recognize that State, local, and Federal authorities will always have to be on guard to prevent health care rip-offs from preying on older customers.

In my remaining time, Senator, I would like to turn to the other area of fraud that my office, unfortunately, sees all too often. Our

Medicaid Fraud Control Unit investigates and prosecutes a wide variety of criminal health care fraud cases.

Though much of our work tries to ensure that Medicaid funds are properly used, we also investigate and prosecute cases of physical and financial abuse of residents of Medicaid-funded health care facilities. Some of the cases we are investigating right now might help to illustrate the kind of criminal activities we are seeing. For example, we have an ongoing investigation into possible thefts by nursing home administrators and staff. In one case, money is missing from a patient's trust fund account. In another, the administrator appears to have pocketed Medicaid payments that should have been given to an elderly patient as reimbursement for out-of-pocket expenses. We are all too often seeing cases of family members who have turned against other family members who are confined to nursing homes. In one such case a nephew who had been given the power of attorney for his elderly aunt embezzled thousands of dollars from her bank account. The woman was left without enough money to pay for her nursing home costs, and she was nearly involuntarily transferred out of the home.

Though I realize it is hard to predict what kind of health care reforms might come out of Washington during the upcoming months, one point is painfully obvious. None of the health care reform bills now circulating in Congress provide any role for State Medicaid Fraud Control Units. Such units have great expertise in successfully investigating and prosecuting cases in health care fraud. I would urge your Committee to review the recommendations recently made by the National Association of Medicaid Fraud Control Units. The recommendations speak directly to the need for strong investigation and prosecution units on a State level to attack fraud by health care providers, administrators, and contractors.

Last month we passed a resolution at the summer meeting of the National Association of Attorneys General on this issue. In it we specifically urged Congress to make sure that any health care reform legislation includes strong State authority to prosecute patient abuse and neglect of the elderly in health care facilities and in-home health care programs.

Criminal fraud designed to steal taxpayers' dollars and financially abuse older patients will continue to challenge those of us in law enforcement. There will be continued need for strong State oversight, no matter what kind of health care reform is eventually adopted. I hope that you, Senator Kohl, and the other members of the Committee will monitor reform proposals to ensure that older patients are still protected by State fraud control units.

I truly appreciate the chance you have given me to discuss a few of the health care problems my office has seen, and I will be happy to answer questions that you may have.

Senator KOHL. Thank you very much, Attorney General Doyle. Mr. Attorney General, you mentioned the need for more Federal funding of State Medicare Fraud Control Units. As you know, everyone keeps asking government for more services, and as you know the dollars in Washington nowadays are very tight. Do you have any suggestions for us on how we should adequately fund these units and other health care fraud investigations?

Mr. DOYLE. Yes, Senator, and it isn't one that calls for any additional funding. It's one that seeks to make sure that we don't cut current funding. Currently our units are funded by the Federal Government at a 75-percent level, and any audit of our unit or the units around the country will show that the return on that money is enormous and much greater than the investment that's put into it. And it's not only the financial return, it is people knowing that there are criminal prosecutors out there. There is a deterrent value in having people know that they may face criminal prosecution if they play fast and loose with Medicaid money. So having those units is essential. There have been proposals to cut that funding from 75 to 50 percent. That in Wisconsin would mean, frankly, that we would cut one-third of the operation that we currently have ongoing. I have worked hard personally in the last 2 years to upgrade our Medicaid fraud unit. We have increased the number of our prosecutions significantly. Such units have proven to work around this country, and I hope that we will not see a cutback from 75 to 50. So I think it's a case where we're not asking for anything more. We're asking to make sure that we maintain the level that we have.

I think there are some areas that, without a great deal of more money, we can make some real differences in. One of them is in imposing criminal penalty. More and more of this stuff is theft, and we should view this as large scale, national organized criminal activity. The National Association of Attorneys General has worked closely with the FTC and with Federal prosecutors. I do encourage your efforts to see Federal criminal statutes improved to deal with these kinds of issues.

One very simple little thing, for example, is included in the President's crime package. It didn't achieve much notoriety, but is important. The mail fraud statutes should be expanded to include Federal Express and private carriers. Clever rip-off artists know that they can avoid Federal prosecution by not using the U.S. mails for their scams. So, they use private distribution systems, Federal Express and others. We have had very good cooperation from those private companies, but nevertheless, an individual can escape Federal prosecution by using them. I encourage you to look at the expansion of the Federal mail fraud statute to include the private carriers so that they cannot get around the Federal mail fraud laws by using Federal Express.

Senator KOHL. Well, that's very good. I know for a fact, Mr. Attorney General, that the Secretary of Health and Human Services, Donna Shalala, is a person who has enormous regard for you. Would you work with me to convince her that it is not in the best interests of our country to continue to defund this investigatory unit?

Mr. DOYLE. I would be delighted to work with you. I know I have already written her a letter as have attorneys general from around the country, and I know your input in that would be very important as well, and I would be happy to work with you.

Senator KOHL. I thank you and we thank you for coming. You've been very helpful.

Mr. DOYLE. Thank you.

Senator KOHL. Our next panel includes four people who have a great deal of interest in protecting seniors from being targets of health care fraud.

Mr. Tony Valeo is a long-time Kenosha resident and a very active senior citizen, but he became known to people all across our country earlier this year, when he appeared on the ABC news program "Prime Time Live," as they investigated a complaint of eye care clinics operating in Illinois and Wisconsin. He will tell us more about that experience this morning.

Mrs. Wilma Marko is a senior from here in Racine. Mrs. Marko currently has a complaint pending with the Wisconsin Attorney General's office regarding a medical alert device for which she feels she was grossly overcharged.

Our third panel member is certainly no stranger to seniors in Southeastern Wisconsin. Mr. Lou DeMarco is executive director of the Kenosha Senior Action Council, and he is very involved in community activities.

Our final panel member hails from Madison, but very soon he will be representing the interests of seniors nationwide, Mr. Eugene Lehrmann is president-elect of the national AARP, the American Association of Retired Persons. He will serve as national AARP president for 2 years, beginning in May 1994. It is certainly an honor for Wisconsin to have one of our own residents lead this very well-known and very important national organization.

So we would like to thank all four of you for being here with us this morning. Your written testimony has been received and will be entered without objection into the official hearing record.

First we will hear from Mr. Valeo, then Mrs. Marko, then Mr. DeMarco, and finally Mr. Lehrmann. After you have read your statements, I will have questions for each of you.

So Mr. Valeo, if you would please begin the testimony from this panel, we would love to hear from you.

STATEMENT OF TONY VALEO, SENIOR ACTION COUNCIL OF KENOSHA COUNTY, KENOSHA, WI

Mr. VALEO. Good morning, Senator. It's good to be here. I want to commend you for sponsoring the hearing today. It shows you care about old folks and renders a much needed service by looking into the practice of some medical experts who are, at best, inappropriate, and at worst, downright flaws.

Many retirees today are being besieged by these medical experts such as the Desnick Eye Care Clinic in Kenosha, Wisconsin. To participate in a program to have their cataracts removed free of charge, they are being lured with offers to be picked up at their home, by limo or van, and returned home after surgery is performed in Waukegan, Illinois. Sam Donaldson from ABC TV contacted Louie DeMarco, the Executive Director of the Senior Action Council, of Kenosha county, to recruit seniors on Medicare to participate in his investigation of the Desnick Eye Clinic. I was one of four who volunteered to take part in this effort. It was a most interesting and stimulating experience for me. I was told I needed cataract surgery in both of my eyes, at no cost to me because I was on Medicare. The charge was $2,400 per eye. No mention was made that it is the taxpayers that would be burdened with this cost.

Donaldson arranged to have a second opinion for me, which contradicted the Desnick verdict. Needless to say, I refused to have cataract surgery and to this day I haven't had it. If there are any questions, I would be glad to answer them.

I wish to thank you, Senator Kohl, for having this hearing, and I also want to commend you for voting for President Clinton's budget proposal. Keep up the good work. If there's any questions, I would be glad to try to answer them, and if you want a more detailed routine of what happened in Kenosha with this investigation, I'd be delighted to enlarge on it.

[The prepared statement of Mr. Valeo follows:]

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SENATOR HERB KOHL'S PUBLIC HEARING

MALPRACTICE — THE FEDERAL GOVERNMENT SHOULD MAKE IT MANDATORY THAT WHEN A DOCTOR LOSES HIS LICENSE, IN ONE STATE, THAT HE SHOULD BE REVOKED NATIONALLY. HIS MEDICAL REVOCATION SHOULD BE ON A NATIONAL NETWORK.

MAIL FRAUD — MAIL ORDER MEDICAL PLANS OR COVERAGE UNDER 65 YRS. OF AGE ARE NOT WHAT THEY CLAIM TO BE. THE SMALL PRINT OR THE INTRODUCTION OF THEIR PACKAGE IS NOT WHAT THEY REALLY MEAN. THE MAIL FRAUD IS A COVER-UP OF CHOICE WORDS, USING WELL KNOWN NAMES TO SELL IS ANOTHER "COME ON".

SURGICAL CLINICS — CLINICS SUCH AS THE DESNICK EYE CENTER THAT THE SENIOR ACTION COUNCIL OF KENOSHA COUNTY, ASSISTED SAM DONALDSON & ABC'S "PRIME TIME" EXPOSED, SHOULD NOT BE ALLOWED TO PRACTICE THEIR MARKETING WAYS WITHOUT MEDICAL RULES OF ETHICS. FREE EYE SCREENING. WAS A PLOY. MEDICARE WAS BILLED. ANOTHER IS UNEEDED SURGURY.

UNEEDED TESTING & SURGURY — MANY DOCTORS, AND CLINCS ARE ORDERING TESTING & AND PERFORMING SURGERYS THAT ARE NOT NECESSARY. ESECIALLY WHEN MEDICARE & OTHER INSURANCE COMPANIES ARE DOING THE FINANCING.

IN CONCLUSION, THERE IS A GREAT AMOUNT OF FRAUD GOING ON IN OUR STATE, AS WELL AS, THE NATION. THOSE WHO HOLD OUR LIVES IN THEIR HANDS. SHOULD HAVE ROUTINE FOLLOW-UPS, AND RE-EVALUATIONS DONE ANNUALLY, OR JUST AT RANDOM. ALSO, DOCTORS SHOULD MANDITORILY KEEP A CONTINUOUS EDUCATION UP-DATE.

Faxed 9-10-93 [illegible] again at 3:05 pm

Senator KOHL. All right. We'll get back to you, Mr. Valeo. We appreciate your being here. We appreciate your testimony.

Mrs. Marko, we would like to hear from you.

STATEMENT OF WILMA R. MARKO, RACINE, WI

Mrs. MARKO. Good morning, Senator Kohl. My name is Wilma Marko, and I live here in Racine. Two years ago I was confronted by the Vital-Link Company of California and Illinois. They offered to sell me a device which would let me push a button on a pendant that would page them for help if I had an emergency. It sounded like a good idea. My husband had died and I was all alone and I felt like I needed something like this if I fell or had a stroke. I had also been having health problems at the time and was in my 80's. They called me a couple of times, and finally I agreed to let a salesman come to my home. When he came to visit, he was quite a salesman. But when it came time to discuss the price, he said I would be shocked, and I was. It was $100 to sign up plus $120 per month for a 2-year contract. Still, I didn't know anything like this was available in Racine, so I signed up. A couple of months later, I heard from a friend at a Christmas party that I could get a similar device from St. Mary's Hospital in Racine for only $15 a month. I didn't know what to do. I didn't get anywhere talking with Vital-Link about getting out of this contract. They said the only way to break the contract was to pay them another $500, which I put on my Visa card. I also paid them for about 5 months for the device. So I lost around $500 or so. I also had to pay an attorney about $100 to help me, and I filed a complaint with the Attorney General's office in Madison. All together I lost over $1,000, when I could have gotten the device for only $15 a month from St. Mary's Hospital. I felt this was a bad experience. I was easily talked into it by a high-pressure salesman. It was hard to say no. I was very angry that I had signed the contract, and they said there was little I could do. Even though I lost all this money, I sent my complaint to the Attorney General's office in Madison. Thank you, Senator Kohl, for letting me tell this story today.

Senator KOHL. Well, we thank you, Mrs. Marko, for coming. It is, indeed, a sad story, and it is very courageous of you to come here and help us inform everybody how serious this problem is. We appreciate your being here. I'll get back to you in a minute with some questions.

Mr. DeMarco, how are you doing?

Mr. DEMARCO. Good morning, Senator.

Senator KOHL. Good to have you here.

STATEMENT OF LOU DE MARCO, EXECUTIVE DIRECTOR, SEN-IOR ACTION COUNCIL OF KENOSHA COUNTY, KENOSHA, WI

Mr. DEMARCO. Glad to be here. Lou DeMarco, representing the Senior Action Council, I happen to be the Executive Director, and we compliment you and your staff for coming down to the Racine/Kenosha area. This is great. And I think this is the grassroots, and I think this is where you're going to get some questions and answers.

I also want to compliment you, also, for supporting President Clinton's fine budget plan that we have, because I know that I was one of the fortunate ones to be invited to the White House to listen to Clinton and Gore and his chief of staff. Of course, you know, some of us came down to see you at your office and it was great. To me it was an exciting point of my life. But I do represent the Senior Action Council which has over 6,500 members, we're great, we're growing every day, and many times we do get cases like the previous speakers spoke about and we do refer them to the great Attorney General we have in the State of Wisconsin, Doyle, and we also refer them to the insurance commission where we know there's no teeth in a lot of the efforts that are put forth in the State of Wisconsin. We need Federal teeth.

A few of the things that I want to discuss is the malpractice. The Federal Government should make it mandatory when a doctor loses his license in one State, then he should be revoked on a national basis so his medical revocation should be on national network, because from what I hear, what I see on national networks, just not too long ago, there was a doctor that went out west somewhere and they just love him out there, but his practice and what he's done was drastic. They kicked him out of Florida and other States, and he's out in the western States now and he's doing his job. Now, that should be corrected on a Federal, with some Federal recommendations and stopped.

Mail order fraud that the Attorney General has brought up. This is really something very serious. Coverage that they send out to people, especially under 65 years of age, are not what they claim to be. The small print that they have in the introduction of their package is not what they really mean.

The mail fraud is a cover-up of choice words. And as you know, we tried to work that out with a previous Congressman, when we had Moody down, and he spoke on that, but they use the certain words and they can get away with it.

We know that maybe in this area you can make some corrections so they can't use the mail, our good USA mails, to be able to go and sell their products, which is not the proper thing to do to many of us that do need the coverage.

Surgical clinics.—Clinics such as brother Tony Valeo brought up. Of course we know they had a correction. If anybody sees their ads now, they say surgery if needed. They'll use choice words. But the pressure is there, and I think some teeth ought to be put into that area so we know that they don't take that Medicare money that is so, as a matter of fact, it's going to be reduced, we would hope that reduction does not affect our Medicare patients. So there's ways that they market their medical rules of ethics. So I hope that the ploy that they use can be corrected.

Unneeded testing and surgery.—Many doctors and clinics are ordering testing and performing surgeries that are not necessary—as you well know, that has been brought up many times—especially when Medicare and other insurance companies are doing the financing. This is one of the things that I happened to make—I've made a few points about this. What they do is when you have to go to a doctor and your doctor, the first thing they do, they call you, especially as a new patient, the doctor asks you or the office girl

will ask you if you've got insurance, what kind of insurance you have, and if you have that good coverage, the red carpet treatment, your billing's going to be a lot different than the average accepting of the Medicare usual and customary charge. A lot of that should be corrected if we're ever going to have something with some good teeth in it.

I would like to just say one short thing here. Doctors are like politicians, are supposed to be servants of the people. Doctors were trained to care, but today medicine got to be a commodity. Taking care of people, healing, comforting, dealing with pain, and the uncertainty should never have a price tag. Providers should be paid but should be addressed in a caring way and not only in a dollar gouging. Many don't have the good working class consciousness, but there is a good number of physicians, a good number that do care, and they are committed to a single payor plan, the same as the Canadian style plan. And that is for a national health program. There's over 4,500 doctors right now that are really dedicated more and they're growing. When the Government creates a national health program, then physicians' fraud can be stopped and can be slowed up.

And I just want to conclude that there is a great amount of fraud going on in our State as well as in the Nation. It's one of those things that's just going to keep going. Those who hold our lives in their hands should have a routine follow-up, the doctors themselves, all providers, and reevaluations done annually, or just at random.

Also, doctors should mandatorily keep a continuous education update. I think that this should be a must just like they do with the teachers. They reevaluate the teachers. I think the doctors and the providers should be reevaluated. This is the way we know they keep up with the modern trends of medicine and the high tech. And we thank you again, Senator, for inviting us here.

Senator KOHL. Well, thank you very much, Lou, that's outstanding testimony and it's very helpful, and I want to thank you for all you've done for seniors for many, many years. Greatly appreciated by everybody.

Mr. Lehrmann, we're delighted to have you, congratulate you on your new appointment. It's a great thing for you, for senior citizens and for the State of Wisconsin. We would love to hear your testimony.

STATEMENT OF GENE LEHRMANN, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. LEHRMANN. Thank you very much, Senator Kohl. It is a pleasure to be here this morning, to be back in Southeastern Wisconsin, where I taught in the vocational system quite a few years ago. I was in Kenosha. I would like to commend you for calling this hearing, particularly to focus attention on the draining of billions of dollars from our health care system through fraud and abuse. I was appalled when I heard your statement that 10 percent of Medicare costs may fall in that category, and that's the area I would like to address.

Before moving on in that regard, I would just like to mention the fact that the $56 billion cut in Medicare costs, the largest in pro-

gram history enacted by Congress last week, is a real situation as far as older people are concerned. To claim that these enormous cuts in Medicare will do no harm, as some people in Washington do, is a misstatement. The cuts will be felt by Medicare beneficiaries across the country in the form of higher premiums and reduced access to needed care. Individuals with private insurance coverage and businesses will also feel it because they will have to pick up the bill that Medicare will no longer pay. I'm pleased with the message that I heard over the radio yesterday, in a statement that you made, that as we consider more, or if Congress considers more reductions in spending, that you did not mention more in Medicare and aging categories. That really is comforting to us when we know what has happened up until now.

In the area of fraud and abuse, the sheer size and complexity of our health care system, its fragmented delivery and payment systems, and the enormous financial resources devoted to it create its unfortunate opportunities for fraud and abuse. Studies have shown, and commonsense confirms, that providers, not patients, are the primary source of the problems. Patients generally cannot admit themselves to hospitals, write prescriptions, or order tests or other medical procedures. Fraud and abuse include a variety of practices that are as creative as they are harmful. You heard of some of them that come through the mail and through solicitation directly.

I want to focus on some that are right in our normal operation of Medicare. Over-billing for services. Knowingly providing and billing for unnecessary services. Billing for phantom services, not those that are rendered. In part due to fraud, total health expenditures in the United States were $752 billion in 1992, and are estimated to reach almost $1.7 trillion by the year of 2000; that is, unless we do something about it. And that thing is that we get busy with health care reform, and we hope that the President will soon announce what his health care reform plan is so that we can all take a look at it. We think it's a step in the right direction from what we have been hearing.

Why don't the various payors come together to address fraud and abuse in a more coordinated manner?

First, the complexity and diversity of billing and payment systems is hard to understand.

Second, private insurers are often reluctant to share claims or medical record information because of both the proprietary nature of their business and privacy concerns.

Third, many insurers have neither the resources nor the breadth of authority to sort out abuse. The greatest need, certainly, is one that will give the Medicare system the authority to look into these situations so that we can do something about it. We need to do much more right now to fight fraud and abuse. We need, for example, to eliminate carriers shopping for durable medical equipment in which these providers and suppliers submitted Medicare claims in the area of the country with the highest payment rates; prohibiting physicians from referring Medicare patients to clinical labs in which the physician has an ownership interest; diminishing the ability for providers to unbundle charges and, therefore, increase payments; and establishing safe harbors that protect legitimate

health care business arrangements while making it more feasible to identify illegal kickback activities.

I would just like to suggest a couple of things that I think are important as far as fraud and abuse are concerned. Along with more coordination and incentives to prevent fraud, greater enforcement measures will be needed. You heard that expressed by, I guess, everybody that was here. Legislation that increases civil and criminal penalties for fraud, particularly in the case of serious injury, would be helpful, as would additional resources for Federal enforcement agencies.

Lastly, heightened consumer awareness can complement these efforts. For instance, AARP has printed articles in both Modern Maturity and the AARP Bulletin which reaches approximately 33 million consumers and has published a special consumer bulletin in cooperation with the National Association of Attorneys General. The ability of consumers to fight fraud and abuse, however, is very limited unless the Government gets involved.

Senator Kohl, thank you for the opportunity to share these talks with you today. My written testimony gives more detail than I was able to give in this period of time. I wish you well as you look into this subject and that we will get some legislation that will be of value.

[The prepared statement of Mr. Lehrmann follows:]

STATEMENT OF GENE LEHRMANN, PRESIDENT-ELECT

GOOD MORNING. MY NAME IS GENE LEHRMAN. I AM PRESIDENT-ELECT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP). I WOULD LIKE TO COMMEND YOU AND YOUR COLLEAGUES HERE TODAY FOR HOLDING THIS HEARING TO FOCUS ON A VERY SERIOUS PROBLEM -- THE DRAINING OF BILLIONS OF DOLLARS FROM OUR HEALTH CARE SYSTEM THROUGH FRAUD AND ABUSE.

SHIFTING COSTS AND SHIFTING RESPONSIBILITY. BEFORE ADDRESSING THIS ISSUE DIRECTLY, I WOULD LIKE TO COMMENT ON THE $56 BILLION IN MEDICARE CUTS -- THE LARGEST IN THE PROGRAM'S HISTORY -- ENACTED BY CONGRESS LAST WEEK. TO CLAIM THAT THESE ENORMOUS CUTS IN MEDICARE WILL NOT DO HARM, AS SOME IN WASHINGTON HAVE ASSERTED, IS A "FRAUD" PERPETUATED AGAINST THE AMERICAN PEOPLE. THE CUTS WILL BE FELT BY MEDICARE BENEFICIARIES ACROSS THE COUNTRY IN THE FORM OF HIGHER PREMIUMS AND REDUCED ACCESS TO NEEDED CARE. INDIVIDUALS WITH PRIVATE INSURANCE COVERAGE AND BUSINESSES WILL ALSO FEEL THESE CUTS AS THEY PICK UP THE BILL FOR WHAT MEDICARE WILL NO LONGER PAY.

SOME IN CONGRESS WANT TO SLASH MEDICARE EVEN MORE UNDER THE GUISE OF "ENTITLEMENT CAPS" AND WITHOUT A BROADER FOCUS ON SYSTEM-WIDE HEALTH CARE REFORM. BUT CUTTING MEDICARE ONLY IS LIKE PUSHING ON A BALLOON AT ONE END -- THE COSTS POP UP SOMEWHERE ELSE. IN FACT, IN A JUNE 1993 REPORT, THE CONGRESSIONAL BUDGET OFFICE FOUND THAT IN THE LAST SEVEN YEARS, MEDICARE SPENDING PER-PERSON GREW AT A MUCH SLOWER RATE THAN SPENDING IN THE REST OF THE HEALTH CARE SYSTEM. WE URGE THE PRESIDENT AND CONGRESS TO TAKE RESPONSIBILITY FOR THE PROBLEMS IN THE HEALTH CARE SYSTEM AS A WHOLE AND MAKE THE TOUGH CHOICES NEEDED TO BRING ABOUT COMPREHENSIVE REFORM.

FRAUD AND ABUSE -- CAUSES AND EFFECTS. THE SHEER SIZE AND COMPLEXITY OF OUR HEALTH CARE SYSTEM, ITS FRAGMENTED DELIVERY AND PAYMENT SYSTEMS, AND THE ENORMOUS FINANCIAL RESOURCES DEVOTED TO IT CREATE UNFORTUNATE OPPORTUNITIES FOR FRAUD AND ABUSE.

STUDIES HAVE SHOWN -- AND COMMON SENSE CONFIRMS -- THAT PROVIDERS, NOT PATIENTS, ARE THE PRIMARY SOURCE OF THE PROBLEM. PATIENTS GENERALLY CANNOT ADMIT THEMSELVES TO HOSPITALS, WRITE PRESCRIPTIONS, OR ORDER TESTS OR OTHER MEDICAL PROCEDURES.

FRAUD AND ABUSE INCLUDE A VARIETY OF PRACTICES THAT ARE AS CREATIVE AS THEY ARE HARMFUL. THESE INCLUDE:

- OVERBILLING FOR SERVICES
- KNOWINGLY PROVIDING AND BILLING FOR UNNECESSARY SERVICES
- BILLING FOR "PHANTOM" SERVICES NOT RENDERED

THE INSURANCE INDUSTRY INITIALLY FOOTS THE BILL FOR FRAUDULENT SERVICES, AND THEN RAISES HEALTH INSURANCE PREMIUMS. EMPLOYERS PASS THE COSTS ONTO CONSUMERS IN THE FORM OF HIGHER PRICES AND LOWER WAGES AND ONTO INDIVIDUAL WORKERS IN THE FORM OF HIGHER PREMIUMS, REDUCED BENEFITS, AND LOWER WAGES. THIS PHENOMENON EXPANDS THE RANKS OF THE UNINSURED AND UNDERINSURED, AND REDUCES ACCESS TO CARE. TO RECOUP THE COST OF CARE PROVIDED TO THOSE WITHOUT INSURANCE, HOSPITALS AND OTHER PROVIDERS OFTEN SHIFT THESE COSTS TO OTHER PAYERS. THE INFLATION SPIRAL CONTINUES.

IN PART DUE TO FRAUD, TOTAL HEALTH EXPENDITURES IN THE UNITED STATES WERE $752 BILLION IN 1992 AND ARE ESTIMATED TO REACH ALMOST $1.7 TRILLION BY THE YEAR 2000.

EVEN MORE STRIKING IS HOW FRAUD AND ABUSE SAP THE PUBLIC'S CONFIDENCE IN THE HEALTH CARE SYSTEM. A RECENT SURVEY OF THE PUBLIC'S ATTITUDE TOWARD THE HEALTH CARE SYSTEM PREPARED BY DYG, INC. FOR AARP INDICATES A DEEPLY-HELD CYNICISM ABOUT OUR SYSTEM, FUELED IN PART BY FRAUD AND ABUSE.

FRAUD AND ABUSE FEED ON THE FRAGMENTATION OF OUR HEALTH CARE SYSTEM. CURRENTLY, OVER 1,000 PAYERS FOR CARE PROCESS ABOUT 4 BILLION CLAIMS ANNUALLY -- OFTEN UNDER VERY DIFFERENT PAYMENT RULES AND USING DIFFERENT PAYMENT SYSTEMS. THE PROBLEM IS ONE OF MANY POCKETS OF FRAUD AND ABUSE IN EACH OF THE DIFFERENT INSURER AND PAYMENT SYSTEMS. ONE APPROPRIATE ANALOGY MIGHT BE THAT OF THE PROLIFERATION OF DRUG SMUGGLING INTO THE COUNTRY. OUR BORDER IS SO LARGE THAT WHEN ONE SMUGGLING ROUTE IS SHUT DOWN, OTHERS OPEN UP JUST AS QUICKLY.

WHY DON'T THE VARIOUS PAYERS COME TOGETHER TO ADDRESS FRAUD AND ABUSE IN A MORE COORDINATED MANNER?

- FIRST, THE COMPLEXITY AND DIVERSITY OF BILLING AND PAYMENT SYSTEMS IS DAUNTING;

- SECOND, PRIVATE INSURERS ARE OFTEN RELUCTANT TO SHARE CLAIMS OR MEDICAL RECORD INFORMATION BECAUSE OF BOTH THE PROPRIETARY NATURE OF THEIR BUSINESS AND PRIVACY CONCERNS.

- THIRD, MANY INSURERS HAVE NEITHER THE RESOURCES NOR THE BREADTH OF AUTHORITY TO SORT OUT ABUSE.

THE GREATEST NEED IS FOR NATIONAL HEALTH CARE REFORM, INCLUDING A COMPREHENSIVE DATA SYSTEM TO SHARE MEDICAL CLAIMS INFORMATION AND IDENTIFY PATTERNS OF FRAUD AND ABUSE.

TO BE SURE, COMPREHENSIVE HEALTH CARE REFORM WILL NOT COMPLETELY ELIMINATE FRAUD AND ABUSE. THERE IS NOT A SIMPLE BUDGET LINE-ITEM FOR FRAUD AND ABUSE THAT WE CAN ELIMINATE WITH A STROKE OF THE PEN.

SIMILARLY, THE "SAVINGS" FROM REDUCED FRAUD AND ABUSE WILL NOT PAY FOR THE COSTS OF REFORMING THE HEALTH CARE SYSTEM.

FOR OUR PART, AARP BELIEVES THAT COMPREHENSIVE REFORM OF OUR HEALTH CARE SYSTEM IS NEEDED IF WE ARE TO GAIN CONTROL OF RISING HEALTH CARE COSTS AND ASSURE ACCESS TO QUALITY CARE FOR ALL INDIVIDUALS. THE ASSOCIATION SPENT THE LAST FEW YEARS LISTENING TO OUR MEMBERS' CONCERNS ABOUT THE CURRENT HEALTH CARE SYSTEM AND THEIR CALL FOR COMPREHENSIVE REFORM. THE AARP PROPOSAL FOR REFORM -- KNOWN AS "HEALTH CARE AMERICA" -- IS A BOLD APPROACH THAT OFFERS HOPE AND SECURITY TO ALL INDIVIDUALS, YOUNG AND OLD. IT PROVIDES A VISION OF WHAT AN EFFICIENT AND ACCESSIBLE HEALTH CARE SYSTEM COULD BE IF WE HAD THE NATIONAL LEADERSHIP TO MAKE IT HAPPEN.

BUT MUCH MORE CAN BE DONE RIGHT NOW TO FIGHT FRAUD AND ABUSE. SOME OF THE STRATEGIES THAT HAVE BEEN INSTITUTED OVER THE LAST SEVERAL YEARS IN MEDICARE ARE BEGINNING TO PROVE SUCCESSFUL.

- ELIMINATING "CARRIER SHOPPING" FOR DURABLE MEDICAL EQUIPMENT (DME), IN WHICH DME SUPPLIERS SUBMITTED MEDICARE CLAIMS IN THE AREA OF THE COUNTRY WITH THE HIGHEST PAYMENT RATES.

- PROHIBITING PHYSICIANS FROM REFERRING MEDICARE PATIENTS TO CLINICAL LABS IN WHICH THE PHYSICIAN HAS AN OWNERSHIP INTEREST.

- DIMINISHING THE ABILITY FOR PROVIDERS TO "UNBUNDLE" CHARGES AND THEREBY INCREASE PAYMENTS; AND

- ESTABLISHING "SAFE HARBORS" THAT PROTECT LEGITIMATE HEALTH CARE BUSINESS ARRANGEMENTS WHILE MAKING IT MORE FEASIBLE TO IDENTIFY ILLEGAL KICKBACK ACTIVITIES.

SOME OF MEDICARE'S SUCCESSFUL STRATEGIES COULD BE USED TO REDUCE FRAUD AND ABUSE IN PRIVATE INSURANCE AS WELL.

WE OFTEN FORGET THE BILLIONS OF DOLLARS IN FEDERAL TAX EXPENDITURES -- $47 BILLION IN 1992 -- THAT EMPLOYERS RECEIVE BY EXCLUDING HEALTH INSURANCE PREMIUMS FROM THEIR TAX LIABILITIES. PRIVATE INSURERS, OF COURSE, ALSO BENEFIT FROM THIS INCENTIVE TO BUY COVERAGE.

YET OUR FRAGMENTED SYSTEM MAY EVEN CREATE INCENTIVES FOR PRIVATE INSURERS NOT TO BE VIGILANT IN PREVENTING AND IDENTIFYING FRAUD AND ABUSE.

WITH THIS IN MIND, IT MAY BE APPROPRIATE FOR THE CONGRESS TO CONSIDER REQUIRING THAT AS A PRECONDITION FOR PREFERENTIAL TAX TREATMENT, EMPLOYERS PURCHASE INSURANCE FROM COMPANIES THAT ARE IN COMPLIANCE WITH GOVERNMENT STANDARDS TO:

(1) AGGRESSIVELY SEEK OUT FRAUD AND ABUSE, AND

(2) COORDINATE THESE STRATEGIES ACROSS ALL PAYERS.

ALONG WITH MORE COORDINATION AND INCENTIVES TO PREVENT FRAUD, GREATER ENFORCEMENT MEASURES WILL BE NEEDED. LEGISLATION THAT INCREASES CIVIL AND CRIMINAL PENALTIES FOR FRAUD, PARTICULARLY IN THE CASE OF SERIOUS INJURY, WOULD BE HELPFUL, AS WOULD ADDITIONAL RESOURCES FOR FEDERAL ENFORCEMENT AGENCIES.

LASTLY, HEIGHTENED CONSUMER AWARENESS CAN COMPLEMENT THESE EFFORTS. FOR INSTANCE, AARP HAS PRINTED ARTICLES IN BOTH MODERN MATURITY AND THE AARP BULLETIN -- WHICH REACHES APPROXIMATELY 34 MILLION CONSUMERS -- AND HAS PUBLISHED A SPECIAL CONSUMER BULLETIN IN COOPERATION WITH THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL. THE ABILITY OF CONSUMERS TO FIGHT FRAUD AND ABUSE, HOWEVER, IS VERY LIMITED.

SENATOR KOHL, AND MEMBERS OF THE SELECT COMMITTEE ON AGING, THANK YOU FOR THE OPPORTUNITY TO TESTIFY TODAY. AARP HOPES TO CONTINUE WORKING WITH YOU AND YOUR COLLEAGUES IN THE SENATE TO REDUCE FRAUD AND ABUSE AND TO MAKE OUR HEALTH CARE SYSTEM ONE THAT WE CAN ALL BE PROUD OF.

Senator KOHL. Thank you, Mr. Lehrmann. Excellent testimony. I will get back to you with a couple of questions in just a minute.

Mr. Valeo, when you went to this eye clinic that you talked about this morning, how interested were they at the eye clinic in how you would pay for their services?

Mr. VALEO. The first thing they ask you is, are you on Medicare? Then they show you a little clip on TV, about 10 minutes, while you're waiting for a doctor to be sprung loose, and that's it. As long as you've got Medicare, you've got free service is what they keep drumming at you. It reminded me of Willie Sutton when he got arrested for robbing banks. They say, why do you hold up banks? And he says, because that's where the money is. As long as you've got a Medicare card, they figure the taxpayers are just limitless in their ability to pay.

Senator KOHL. So it was understood that there was no cost to you?

Mr. VALEO. That's right.

Senator KOHL. But the cost was going to be borne entirely by Medicare.

Mr. VALEO. Right.

Senator KOHL. And as a result it was, quote, "a free service;" is that what they were trying to say?

Mr. VALEO. That's what they were saying. I don't know if they're still saying that now, because they're not practicing in Kenosha anymore. The owner of the property that they were renting didn't like the bad publicity that was coming out, so——

Senator KOHL. He closed them up.

Mr. VALEO. One day a week. So I don't know if they're still there, but they'll take you to Waukegan. They'll pick you up at home and take you to Waukegan.

Senator KOHL. Well, after they told you that you needed surgery, Mr. Valeo, did they then continue to call you and badger you and try and get you to agree?

Mr. VALEO. Indeed, they did. Indeed, they did. They came to my home to pick me up on the day I was supposed to have the surgery. I was still in my bathrobe, and I went to the door, and I says, I'm not feeling well today. He says, is it something we did? The driver said. A very personable man. I says, no, I'll let you know when I'm ready. And that's it. He left. They didn't go any more than that.

Senator KOHL. Thank you. All right. Mrs. Marko, how much pressure was there to buy this Vital-Link's device that you talked about and how often did they call you before you agreed to meet with them?

Mrs. MARKO. Oh, I would say it was about two or three times. Now, I did talk with my son, and of course he didn't know anything about the hospital here, and so he advised me, he thought it was a good idea because I was alone, and so I finally consented because I thought, well, it'll be $100 a month, and he was such a good salesman, and I'm always rather weak when it comes to a good salesman, you hear, but anyway, my son advised me, and my daughter thought that it would be a good idea because I was living alone, and I am a diabetic, and I take insulin and am doctoring, and I felt that it would be something good for me if I needed help, but when I found out through this friend at the Christmas party,

I was just shocked, and she couldn't believe that I had signed up for something like that.

Senator KOHL. Did they pressure you with all kinds of fear stories and try to prey on the fact that you live alone and that you're a widow?

Mrs. MARKO. Yes. Oh, yes. And he went all around the house so that the device—he put a little tag on my ice box, and he went all around the house so that I could go out with this chain and it would register out in the yard.

And also, I wanted to know if there was someone in Racine, and he did give me the name of someone, and I called her, and at the time she had fallen in her yard and had called them. And now I don't know, it must have gone to the hospital here in Racine. I mean when you press the button, I would think that the paramedics in Racine come after you, but this was through California and in Illinois, Perry, Illinois.

Senator KOHL. Well, when you decided you no longer wanted the service, no longer wanted the device with this company, how were they? Were they helpful to you in terminating it? Did they make it inconvenient, difficult? What happened?

Mrs. MARKO. They said that there was no way that I could get out of it.

Senator KOHL. They told you there was no way that you could get out of it.

Mrs. MARKO. No. That I would have to pay. They did say that I could pay $500, because they knew that I was very, very upset, and I talked to her and told her that I had talked to this friend of mine and that they have the same thing here in Racine in the hospital, which I didn't know about, and I couldn't talk her out of it. That's when I, afterwards, went to a lawyer to try and get some help.

Senator KOHL. Thank you. Thank you, Mrs. Marko. You've been very helpful.

Mr. DeMarco, you mentioned this problem where a doctor may lose his license in one State yet moves to another State and just continues in business. Do you have any suggestions as to how we might solve that problem which is a very real and a very serious one?

Mr. DEMARCO. I think I've heard other doctors in organizations discuss this issue, and it seemed like the Medical Association could have done something good on that; don't really want one doctor against another, that seems to me that's the way it works. But the way we've discussed it, and I've discussed it here with this great organization right now that's been put together, with many, many physicians and providers, and one of them in particular, Dr. Boston from California, he says the Federal Government really should start putting some teeth into this area, because a doctor that has committed a serious crime, as far as I'm concerned, whether it was death in the procedure, in the surgery, which was uncalled for, or something that was not even done, like for instance, it was a case of where a doctor, this particular doctor, was on major network a week ago, where this doctor created something very major, and the State of Florida, I think it was in Florida, just took his license away and removed him, but that license is as far as the State line

is, that's as far as it went. And the daughters—and I'm pretty sure that the Federal Government should now put their teeth into this kind of an area, because that's our lives that they have to take care of. And if one doctor can do this, then I'm pretty sure that he should, he or she, should be carried throughout the country in a network. I think a network should be set up through the Federal Government. They have their own network. You and I know that when you want to find out if a doctor's qualifications are good, you can check on whatever that qualification is in that certain field. I think that network should be set up in every State before they're certified in their State and their county and the hospitals. They should have that name at their fingertips, that when that doctor comes in, and he wants to practice, say in Kenosha, Kenosha hospitals, Racine hospitals, they have that name there, hey, this is what this person did.

Senator KOHL. Thank you very much, Mr. DeMarco.

Mr. Lehrmann, as the national leader of the AARP, would you tell us where you feel we should focus most of our efforts on health care fraud? Should we spend more time on consumer protection and awareness or should we spend an equal amount or more time on law enforcement?

Mr. LEHRMANN. Certainly, as an educator, I would start out by saying one thing that we all have to make an effort on is educating the public, and AARP, as I indicated, does have a vehicle for doing that, and we are using it, and I'm sure other organizations with aging people involved do the same thing.

However, we need to go beyond that, I believe, and as I pointed out, if we set this up and if we finance this within the Medicare system, what we recover from these fraudulent activities should more than pay for any money that we spend. In fact, if we only saved 1 percent, we would have money in our pocket, as far as the population is concerned, and there would be less fraud involved. I think it's an area that we need to target on, and we've been negligent by not moving before now.

Senator KOHL. In this area of home health care, which you know, Mr. Lehrmann, is growing by leaps and bounds and is largely unregulated, would you support, would you work, to see to it that we get the proper kind of legislation at the Federal level to regulate home health care and how it operates?

Mr. LEHRMANN. Absolutely. That lends itself to a lot of fraud and abuse if we don't have some kind of guideline, something that's set up at the Federal level and administered at the State level, to make sure that people are protected when individuals come into their home and provide health care services in their home. It's possibly going to be the fastest growing activity in the whole health care arena in the immediate future, because more and more people are living to older lives, and we have to do something to protect those people. I would encourage it and AARP certainly would encourage it.

Senator KOHL. Well, thank you, Mr. Lehrmann, and thank you very much, folks. You've been very, very helpful, provided some dramatic testimony, and I think that you could expect and hope to see some positive results as a result of your effort in coming here this morning and telling us about your experience. Thank you.

Mr. LEHRMANN. Thank you.
Mr. VALEO. Thank you. Keep up the good work, Senator.
Mrs. MARKO. Thank you.
Mr. DEMARCO. Thank you, Senator.
Senator KOHL. Thank you very much.

Before we go on to our next panel, I would like to recognize a good friend of mine, State Representative Kim Plache, of the 62nd State assumble District. We appreciate your being here, Kim.

And I would also like to recognize the three people from my staff who have been very helpful in putting together this hearing: Mark Curtis, Lois O'Keefe, and Lynn Becker back there. Thank you very much for your work.

Our next panelist works at the Federal law enforcement level in dealing with health care fraud. We have Michael Dyer here with us. He is the Regional Inspector General for Investigations for the U.S. Department of Health and Human Services, and Mr. Dyer is based in Chicago. Mr. Dyer has numerous years of law enforcement experience, and he is a former special agent for the FBI. The office of the Inspector General works closely with State agencies like the Attorney General's office here in Wisconsin, as well as insurance companies and other groups who are charged with combating this growing problem of health care fraud. The Inspector General's office is also a charter member of the National Health Care Antifraud Association based in Washington, DC.

Mr. Dyer, we want to thank you for driving up from Chicago this morning. We know you have submitted your lengthy testimony which will be included without objection into the official hearing record, and we would like very much to hear a summary of your testimony. Thank you for being with us, Mr. Dyer.

STATEMENT OF MICHAEL DYER, REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS, CHICAGO FIELD OFFICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. DYER. Thank you, Senator. The health care industry is a major industry in America. Unfortunately, health care fraud has also become a major industry as we've discussed here today. When you have health care fraud, there are multiple victims. The Government is certainly a victim, insurance companies are victims, the taxpayer's a victim, individual policy payors are victims. But the most tragic victim of all are those legitimately ill individuals who are entitled to the service, and when they go to receive that service they find that service has been reduced because of dilution of the amount of money available because of fraud.

The Department of Health and Human Services is a major provider of health care in America. They have two major programs, Medicare and Medicaid. Now, those programs are designed to assist the elderly, the ill, the disabled, and the poor. And when individuals take funds from those programs that they're not entitled to, those are the individuals that are injured.

The Inspector General's office has three major processes by which they combat fraud, waste, and abuse. Those three processes are criminal processes. We do criminal investigations and prosecute individuals for taking these funds. We also do civil actions and

where we've recovered the funds, file civil suits through the U.S. Attorney's offices, we go to Federal court and recover funds.

Oftentimes, in most instances, we start with a criminal investigation. Sometimes we fall short of the level of proof, that proof beyond a reasonable doubt, and we then end up filing a civil suit. The proof is less there, it's a preponderance of the evidence level of proof. If we file a suit, we can recover triple damages. We can also recover $5,000 to $10,000 per each false statement by filing those suits.

The third area of where we have action which we can take is through the administrative sanctions and, in essence, we can take an individual who has done wrong to the program of Medicare and Medicaid and we can bar them from billing the Government for a period of time, whether 5 years, up to whatever years. We had a case last week, in fact, an individual selling pacemakers, where we've used two of those. This individual has been sentenced to 6 years in prison. He was selling pacemakers. We did a search warrant, we found that he was paying kickbacks to doctors is the reason we did the search warrant, but in doing the search warrant we found that he had a number of pacemakers which he had bought at a low price. He was able to buy these because they were post-expiration date. He changed the expiration date to make them appear that they would last longer.

In addition to him being sentenced to 6 years in prison, we have sanctioned him for 20 years, so even though he gets out of prison he will not be able to bill Medicare or Medicaid for a total of 20 years. So hopefully he will be out of the business forever. So that's some of the efforts and some of the ways that we have to address Medicare and Medicaid fraud.

Medicare and Medicaid are large programs. They are subject to fraud because of their size. I think the Medicare program is $140 billion, the Medicaid program is $100 billion, of which the Federal Government pays about $72 billion of that $100 billion. So you have extremely large programs, and you have a fairly small staff that is protecting that through the Inspector General's office.

We have various ways that we do try to protect those funds. We have the criminal investigations, which I've talked about, primarily, but we also have audits and inspections and reviews that also do that. In many instances our administrative actions, I think, are very successful in saving money.

For example, on the durable medical equipment area, we had many cases on seat-lift chairs, and these are these chairs that you see on TV that catapult the elderly person up on their feet. We had numerous cases on one particular company that billed us a total of some $50 million over the years. We had numerous criminal cases, we had numerous civil cases, we recovered funds, but the thing that really finally solved that problem was that we came up with suggestions that they would no longer pay for a seat-lift chair, not for the furniture, that they only pay for the device which fits in the chair which will, in fact, provide the service if the elderly person needs that service. That company has in fact gone out of business. It seems the marketing was to sell the chair, and they showed a very attractive chair which the elderly person would buy. In reality, the chair they got was a very shoddy chair, which was a good

marketing technique, because then that chair would be returned, and then the company would sell that chair again. And in some instances we bought the same chair on numerous occasions. So sometimes that administrative solution is even more successful than the criminal solution or the civil solution of getting funds back.

Medicare and Medicaid is certainly vulnerable, I think it's vulnerable to a certain extent just because of the size of Medicare and Medicaid. It's a large amount of funds and you're always going to have some individuals who will try to tap into those funds. The figures we've heard of the amount of loss here are astounding, and certainly, if that loss that's due to fraud could be redirected to those 37 million Americans who are uninsured, it certainly would be a much better use than going to those individuals that are fraudulently submitting bills.

I would like to talk about one particular case that we recently settled, it was the National Health Laboratories. The National Health Laboratories recently returned $110 million to us. This is one laboratory which does blood tests. And the great amount of this fraud was due to two tests. You can see some idea of the vulnerabilities there. When a doctor would submit a request for tests, they would add two tests, which, although they did the tests, actually the first tests that the doctors had ordered would give you the same results. They added two tests which caused millions of dollars to be lost to Medicare and Medicaid. They recently entered into a global settlement with us and returned $110 million. That is the largest agreement ever reached between the Government and a health care provider. I suspect that that record will not stand. We have many large cases in process right now, and I suspect, unfortunately, that we will surpass that.

I would like to discuss a couple of recommendations. The Health and Human Services IG and the Department of Justice have had an ongoing task force, and they've had a number of recommendations. One is that the current Medicare and Medicaid prohibition on kickbacks be extended to all public and private payors. Presently it's illegal to pay a kickback to obtain a patient if it's a Medicare or Medicaid patient. However, on the private side, that is not illegal. Kickbacks greatly inflate the cost of medicine. Those costs are always passed on to the consumer, the insurance company, ultimately the taxpayer, and to the policy payor. We need to do something about that. We have actual competition, bidding for patients, where individuals offer funds for patients. We find that often with psychiatric institutes or providing so much money for each doctor if they will refer a patient into their hospital.

Another thing which has been discussed a number of times here is databases on all final adverse actions against health care providers, whether there is a criminal action, a license being revoked. Each State has its own licensing procedure. If we could have a database, we obviously would have to have protections on that database as to who can gain that access to that information, but law enforcement needs to be able to do that and also the insurance companies need to be able to do that. If an individual is doing fraudulent practice with one insurance company, the other insurance companies need to be able to obtain that.

We also need some legislation to ensure that we can protect these funds due to the rapid change in billing processes. We've leaped into the computer age here. Very soon we will have completely paperless billing. Law enforcement in the past has relied greatly on following a paper trail, finding a false statement, a signature on the document. Those things will disappear, so we have to make sure that providers are held accountable for the accuracy and completeness and truthfulness of the claims that are submitted on these electronic data, and we have to be able to identify the individual that calls in the transmission of the claim. We have to ensure that the patient is provided information, because the patient is our first line of defense. He's often the first one who notes on his explanation of medical benefits, he notes that there's something been billed there that he has not received, and he calls the insurance company and they start their process to find out whether that is an accident, an isolated incident, or whether there's a pattern of fraud there. The insurance companies then collect that information and do the initial investigation and refer that to the Inspector General's office.

I would conclude my testimony with that, but I would certainly be receptive to any questions. I also submitted a much more lengthy written testimony.

[The prepared statement of Mr. Dyer follows:]

Statement by

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Oversight Hearings before the
SENATE AGING COMMITTEE

FRAUD AND ABUSE IN MEDICARE

Good morning. I am Michael Dyer, Regional Inspector General for Investigations from the Chicago field office of the Office of Inspector General (OIG). Thank you for the opportunity to testify on the subject of health care fraud in the Medicare program and what can be done to reduce it. We are pleased that the subcommittee is holding this hearing to discuss the important issue of health care fraud -- a problem that squanders our valuable resources and can adversely affect the health of our beneficiaries. At a time when health care reform is being debated, it is also appropriate that we address these issues to assure that our public health programs operate efficiently and effectively and that changes in our health care financing and delivery systems are made in a manner that minimizes the potential for fraud, waste, and abuse.

The rapid rise in expenditures and deficiencies in our health care delivery system has caused unprecedented attention and scrutiny in the health care area. This scrutiny has encompassed discussions regarding the magnitude and pervasiveness of fraud, waste, and abuse in our health care programs. As you know, the General Accounting Office (GAO) released a report entitled, Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse. The report quotes experts in the health field who estimate the losses to fraud and abuse in health care is 10 percent, or approximately $80 billion in 1992. We will discuss our experience in investigating Medicare and Medicaid fraud later in our testimony.

In discussing monetary losses to health programs, a distinction must be made between fraud, abuse, and waste. It is impossible to distinguish sharply between these terms since frequently one problem involves all three. However, for purposes of rough definitions, we provide the following:

- **Fraud** is defined as the obtaining of something of value, through intentional misrepresentation or concealment of material facts.

- **Abuse** may be defined as any practice which is not consistent with the purpose of providing beneficiaries with medical services which are (1) medically necessary, (2) meet professionally recognized standards, and (3) fairly priced.

- **Waste** is the incurring of unnecessary costs as a result of deficient practices, systems, or controls.

The following examples illustrate these differences:

- A group of physicians operate a diagnostic clinic. To supplement their income, some of the doctors bill Medicare for laboratory procedures on patients, when in fact, no tests are run on these patients. In some instances, the patients do not exist and are not part of the doctor's practice. This is Fraud.

- Other doctors in the clinic will bill Medicare for tests which are performed, but are not actually medically necessary. These tests are usually in addition to a series of tests prescribed for the patient but do not provide the doctor with any additional information that he would not already know from the initial test procedures. This is abuse. If It is the policy of the clinic to give every patient, no matter what their ailment, a complete blood test and cholesterol screening and charge the costs of those tests to Medicare, this also is abuse.

- If the Medicare fee schedule allows Medicare to be billed at a significantly higher rate than would be charged to an outside physician requesting the same test from an independent lab, this would be an example of waste in the program.

Current Health Care Delivery

Currently, Americans are devoting more than 12 percent of our gross national product (GNP) to health care. Roughly three quarters of a trillion dollars were spent in this country on health care last year. This figure is expected to rise dramatically -- one projection indicates that health care expenditures could consume 31.5 percent of our GNP by the year 2020.

The Department of Health and Human Services (HHS) is the Federal Government's principal agency for promoting the health and welfare of Americans and providing essential human services to persons of every age group. The Department's two largest health programs are the Medicare and Medicaid programs, which are administered by the Health Care Financing Administration (HCFA). Medicare provides health insurance coverage to approximately 36 million beneficiaries aged 65 and older and to certain disabled individuals. The Medicaid program provides grants to States for the medical care of more than 30 million low-income people. Expenditures for the Medicare program totalled $140 billion in FY 1992 and expenditures for Medicaid totalled $100 billion ($72 billion Federal share).

How Fraud and Abuse Are Investigated

Office of Inspector General

Created in 1976, the OIG is statutorily charged with protecting the integrity of departmental programs, as well as promoting their economy, efficiency and effectiveness. To meet this goal, the OIG conducts a comprehensive program of audits, inspections, program evaluations, and investigations. The Inspector General Act of 1978, as amended by the Inspector General Act of 1988, requires the Inspector General to "provide policy direction for and to conduct, supervise, and coordinate investigations relating to the programs and operations" of HHS.

The OIG reviews all violations involving Department program fraud including, but not limited to, contractors, program providers and beneficiaries, and Government employees. The OIG relies on three enforcement remedies: (1) criminal prosecution, (2) civil prosecution, and (3) administrative sanctions. All investigations can result in one or more of these remedies being employed. When a complaint is received, it is evaluated to determine the most appropriate course of action to take. The highest priority, of course, would be criminal prosecution. The OIG refers investigative findings directly to the United States Attorneys for possible criminal or civil prosecution. The OIG reported 168 successful health care prosecutions in FY 1992.

With regard to our Medicare investigations, cases that are investigated and presented to the Department of Justice, but declined for criminal or civil prosecution, can then be pursued by HHS under civil monetary penalty authorities. The number of providers and practitioners excluded from program participation by the OIG increased from 230 in FY 1983 to 1,603 in FY 1992. With respect to civil monetary penalties, in FY 1983, 6 cases were resolved by the OIG resulting in recoveries of $1.4 million, as contrasted with FY 1992, when 136 cases were resolved resulting in recoveries of $28.6 million.

The OIG also conducts many joint investigations with other law enforcement agencies such as the State Medicaid Fraud Control Units, the Secret Service, the Federal Bureau of Investigation, the Postal Inspection Service, the Internal Revenue Service, and other OIGs.

Over the years, the OIG has proved to be a sound investment. In FY 1992, the OIG generated savings, restitutions, penalties and interest of over $61 for each Federal dollar invested in its operation. In FY 1992, we imposed 1,739 administrative sanctions on individuals and entities who defrauded or abused the Medicare and Medicaid programs or their beneficiaries. That is more than 44 times the level we reported in 1981. Successful health care prosecutions in the criminal courts have also dramatically increased, from 20 in 1982 to 168 in FY 1992. In fact, FY 1992 marked our 12th consecutive increase in successful prosecutions. We are pleased with the accomplishments we have had in ensuring that beneficiaries receive quality care, that the integrity of the trust fund is maintained and that those individuals who defraud the Department's programs are held responsible for their actions.

Health Care Financing Administration and Medicare Contractors

The Health Care Financing Administration also works to deter fraud, primarily through its Medicare contractors. Historically, the Medicare contractors have always had the responsibility of detecting and developing suspected fraud cases for referral to the OIG. This was known as their program integrity function, and was frequently done in the Medical Review and Utilization Review Units. Some contractors had separate program integrity units; however this was rare.

In Fiscal Year 1993, HCFA accelerated its efforts to deal with Medicare fraud. HCFA initiated a broad effort to get the intermediaries and carriers to take a more active role in detecting, developing and referring potential fraud cases to the OIG and the Department of Justice. HCFA's renewed dedication resulted in consolidating all "program integrity" functions into one Fraud Unit. Funding for these activities will total approximately $24 million in FY 1993.

Medicare Fraud Units have been established at 30 carriers throughout the United States. In addition, 4 other Medicare Fraud Units have been established at the Durable Medical Equipment Regional Carriers. These units work closely with the medical and utilization units as well as other contractor divisions. The Fraud Units' primary role is to identify suspected fraud and to develop and refer these cases to the OIG for consideration and initiation of criminal, civil monetary penalty, or administrative sanction actions.

Medicare Beneficiaries

Beneficiaries represent our first line of defense in preventing Medicare fraud and abuse. After a Medicare service is provided, a beneficiary receives an explanation of Medicare benefits (EOMB). After receiving this notification, a beneficiary may believe that Medicare was billed - and paid - for services the beneficiary did not receive. Beneficiaries often report these concerns.

Medicare contractors operate toll-free hotlines to handle these beneficiary complaints and are required to immediately conduct an investigation to determine whether fraud or abuse has occurred. If the contractor determines that the complaint arose out of a misunderstanding or a bill processing error, the contractor may close out the investigation. However, the contractor must conduct a detailed evaluation of all cases in which fraud is suspected, and they are required to refer these cases to OIG when strong evidence of fraud exists. The procedures are structured this way because preliminary work by contractors can address routine billing complaints, complaints based on honest mistakes, and clerical errors. The contractors can also help clear up any misunderstandings of the part of beneficiaries regarding the information on the EOMB form.

Peer Review Organizations

The utilization and quality control peer review organizations, or PROs, are physician groups in each State which contract with HCFA to review the care rendered to Medicare inpatients. In place since 1983, they review medical records to determine if admissions were appropriate, billing was correct, and care was appropriate. They have the authority to place physicians and hospitals under intensified review, require corrective action plans or other disciplinary actions, and ultimately refer for sanction those providers who render poor quality care or care that is not medically necessary.

State Medicaid Fraud Control Units

For Medicaid, the OIG has oversight authority over State-administered Medicaid Fraud Control Units (MFCUs). The MFCUs, funded in large part with Federal funds, devote over 1,000 personnel to investigating Medicaid fraud. Federal outlays for operation of the MFCUs are estimated to be in excess of $63 million for FY 1993. The MFCUs generally use State statutes to prosecute Medicaid fraud. In FY 1992, the MFCUs reported 667 convictions.

National Health Care Anti-Fraud Association

Until recently, private health insurance programs had no cohesive investigative impact on fraud. To address this issue, in 1985 we helped launch and were one of the founding members of the National Health Care Anti-Fraud Association (NHCAA). It is a consortium of our office, HCFA, the FBI, State Medicaid Fraud Control Units, private health insurers, and others who coordinate and share information and techniques for dealing with health care fraud. Our office has been on the board of directors since its inception. In addition to working on joint projects with this group, we help train the members in better detection techniques and alert them to new types of health fraud.

Prior to the inception of the NHCAA, private carriers did not have a means to share information in order to enhance the identification, prevention, detection, and prosecution of health care fraud. NHCAA was established on the premise that the diverse interests of health insurance reimbursement organizations, Blue Cross and Blue Shield organizations, private corporations and Federal and State agencies and law enforcement operations could be channeled toward a common goal. The association currently consists of several hundred representatives from these types of organizations. NHCAA promotes information sharing among members (with appropriate legal safeguards), engages in public education on health care fraud issues, trains members and non-members through national and regional conferences, seminars, and workshops, and serves in an advisory capacity to industry, regulatory, and legislative bodies.

How Fraud and Abuse Are Prosecuted

Over the years, various legal authorities have been utilized by the Federal Government to redress the proliferation of health care fraud and abuse. As those who have perpetrated health care fraud and abuse have become more sophisticated in their methods, alternative legal remedies have been used by law enforcement agencies to sanction offenders.

Criminal Authorities

Federal prosecutors have sought to redress heath care fraud by using traditional criminal authorities including mail and wire fraud, the false claims, and false statements statutes. Additionally, Congress has enacted criminal statutes directed specifically to prevent health care fraud and abuse within Federal health care programs. Such authorities include criminal sanctions for false claims and statements specifically involving the Medicare and Medicaid programs, and the Medicare and Medicaid anti-kickback statute. The anti-kickback statute prohibits an individual or entity from offering, paying, soliciting, or receiving remuneration with the intent to induce or in return for the referral of Medicare or Medicaid program business.

Civil Authorities

Federal prosecutors also rely upon civil authorities for combatting health care fraud and abuse. Foremost is the civil False Claims Act which authorizes the Federal Government to recover treble damages, a civil penalty of between $5,000 and $10,000 for each false claim, and costs.

Administrative Sanctions

The Department is authorized to impose two types of administrative sanctions against health care providers who defraud or abuse the Medicare and Medicaid programs: civil monetary penalties (CMPs) and program exclusions. Since 1972 HHS has had the authority to exclude from participation in Medicare and Medicaid those health care providers and practitioners determined to have engaged in fraudulent or abusive practices. In 1981, Congress authorized HHS to impose CMPs, assessments, and program exclusions on individuals and entities who submit false or improper claims for Medicare or Medicaid reimbursement.

Since the first CMP was enacted in 1981, Congress has greatly expanded this authority to apply to such improper practices as (1) hospitals and physicians making and receiving payments in order to induce the reduction or limiting of services provided to program beneficiaries; (2) health maintenance organizations failing to provide medically necessary items and services; (3) individuals and entities engaging in certain misleading or fraudulent practices with respect to the marketing or selling of supplemental (medigap) insurance policies and (4) "patient dumping."

The law and implementing regulations for these administrative sanctions provide for due process to be afforded to sanctioned providers and practitioners through review by an administrative law judge, the Departmental Appeals Board, and ultimately the Federal courts.

Medicare and Medicaid Fraud and Abuse Vulnerabilities

Fraud is invisible until detected. Because of that fact, it is extremely difficult to estimate the total monetary loss as a result of fraud in the health care industry. While we cannot assign a dollar figure to the monetary loss to the Medicare and Medicaid programs as a result of fraud, we can tell you that we have noticed a dramatic increase in our investigative workload. This is caused, in part, by the ever expanding size of these programs. The increase in administrative and prosecutable authorities that the Congress has enacted is also a contributing factor. Finally, there may also be an increase in fraud in absolute terms.

The types of health care fraud that confront us has dramatically changed over the years. This is a direct result of the rapid dynamic changes in heath care itself. In the 1970s, we found that we were dealing with individual provider fraud which involved relatively uncomplicated schemes, such as filing a few false claims, resulting in a few thousand dollars of loss to the Medicare program. As medical technologies and health care delivery systems have developed over the years, new schemes to defraud or abuse them have also developed. Today, however, instead of schemes which involve only one person or entity, it is now common to see cases involving groups of people who are intent on defrauding the Government. And these schemes are perpetrated in a far more complex environment and often involve the use of sophisticated computer techniques and complicated business arrangements. The fraudulent $60 x-ray submitted by the local physician is being replaced by the $1,500 MRI billed by a local corporation operating many radiology centers. These crimes frequently result in tens of millions of dollars in losses to Medicare and Medicaid, as well as other public and private health insurance programs.

These changes to our health care system have resulted in a dramatic increase in the investigative workload at the OIG. The most prevalent type of fraud that the OIG investigates is billing for services not rendered. The second most pervasive type of fraud encountered is inaccurate claims. This typically involves manipulating coding systems to obtain higher reimbursement by upcoding or unbundling charges. The third most pervasive area of fraud that we investigate is the area of kickbacks. A kickback occurs when anything of value is given in return for the referral of a health care item or service payable under the Medicare and Medicaid programs. Determining whether a kickback violation exists is complicated when physicians who make referrals to a medical facility also own or have a management interest in the facility. Other cases we deal with involve rendering of services that are unnecessary or inappropriate.

While fraud permeates all areas of our health care system, it is more prevalent in some settings than in others. The OIG has been active for many years in investigating fraud in home health agencies, psychiatric clinics, the durable medical equipment (DME) industry, and the laboratory industry. Because of the limited time we have today, we have selected a few examples of fraudulent and abusive practices that will give you a broad overview of our office's investigations.

Billing For Services Not Rendered

The majority of our workload continues to involve billings for services not rendered. These cases are more readily accepted for prosecution by the United States Attorney and are responsible for the bulk of the convictions obtained in the health care field. I would like to describe three of the Wisconsin cases which we investigated, the first of which involves billing for services not rendered.

- Between January 1991 and April 1992 a Wisconsin therapy company charged for speech therapy services that were not provided and received more that $29,290.00 in overpayments. The settlement agreement called for the owner to repay the full overpayment plus a fine of $15,000.00. The owner's attorney noted that the 50 percent penalty was worse than the Internal Revenue Service would have charged.

- In the second case, three individuals associated with a telemarketing firm and others were sentenced in New York for their part in a kickback scheme. The case was based on a complaint by a Wisconsin hospital official that the telemarketing firm was pressuring them to purchase computer cleaning supplies, offering "premiums" such as television sets and VCRs in return. One of the firm's owners, was sentenced to 5 years probation and ordered to pay a $125,000 fine. His son, who acquired and shipped the kickback items, was also sentenced to 5 years probation and fined $10,000. A company salesman was sentenced to 3 years probation. All three cooperated in the investigation.

- Third, the manager of a Wisconsin durable medical equipment (DME) company was sentenced to 1 month in jail and 1 month in a half-way house for falsely billing the Medicaid program for diaper services. The man had forced employees to bill Medicaid for adult diapers when the company was actually supplying children's diapers, thereby obtaining almost double reimbursement. He was also ordered to pay a fine of $1,000 and a $25 special assessment. A Medicaid overpayment of $19,452 was collected earlier from his company. On the basis of this case, an undercover project was conducted at four companies in the Milwaukee area to determine whether other DME companies were executing a similar scheme. Although none of the undercover purchases were found to be improperly billed, the companies were found to be receiving an overpayment. A total of $46,046.00 was collected and returned to the Medicaid program.

Inaccurate Claims

The Medicare program loses money when providers submit inaccurate claims that do not reflect the services actually performed or the supplies actually delivered. Gaming can take the form of unbundling and upcoding. Unbundling occurs when doctors and other providers submit bills piecemeal rather than for the procedure or product as a whole. A major unbundling case is described later in this testimony.

Upcoding occurs when a product or service is billed using a code for a similar, but slightly more complex product or service. This results in a higher reimbursement rate than is appropriate for the product provided or the service which was actually rendered. For example, saying a patient had a stroke instead of a less serious transient ischemic attack would mean approximately $1,450.00 in additional payment to the average hospital. Similarly, calling the removal of a small wedge of tissue for a biopsy a "resection" could mean as much as $9000.00 being overpaid for the procedure.

Kickbacks

Physician ownership of and compensation from entities to which they make referrals is a practice that has increased considerably in the last 10 years. The medical profession relies heavily upon referrals because of the myriad specialties and technology associated with health care. If referrals of Medicare or Medicaid patients are made in exchange for anything of value, however, both the giver and receiver may violate the Federal anti-kickback statute. Since 1987, we have received more than 1,569 allegations of violations of the anti-kickback statute, and have opened over 1,012 cases. Over 635 convictions, settlements, and exclusions have been obtained as a result of our investigations, as well as almost $18.2 million in monetary recoveries. Research continues to determine the extent to which increased costs are a problem for other items and services that these joint ventures furnish.

Home Health Agency Fraud

Home health agencies (HHA) provide care in the patient's home, with limited supervision by the attending physician. There are several categories of fraud which we have seen in HHA operations: cost report fraud; excessive services or services not rendered; use of unlicensed or untrained staff; falsified plans of care and forged physician's signatures; kickbacks; and intermediary hopping. Since 1986, we have concluded 24 successful criminal prosecutions of HHAs and their employees. Since 1991, we have excluded 15 HHAs, owners or employees from participating in Medicare.

Psychiatric Clinics

Fraud involving psychiatric clinics can take many forms. In a scheme we have seen recently, hospitals pay physicians up to $2,000.00 for the referral of patients to the facility. The amount of money is dependent on the number of patients referred to the hospital by the doctors. The payments to the doctors by the hospital are included as part of the costs incurred by the hospital on the cost reports that are submitted to Medicare. The payments received by the doctors are ostensibly for the writing of patient care manuals that will be utilized by the hospital in its care of the patients, but these manuals are never written. Services for both inpatients and outpatients are not rendered by the hospitals. In some instances, when the Medicare benefits run out for a particular diagnosis, the patient is re-diagnosed to ensure Medicare or Medicaid coverage.

Durable Medical Equipment (DME)

For many years, we have issued reports documenting fraudulent, abusive and wasteful practices in the DME area. Seat lift mechanisms, transcutaneous electrical nerve stimulators, oxygen equipment, home dialysis systems and similar equipment are reimbursed by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this requirement through aggressive sales practices, tricking physicians into signing authorizations and even forging their signature. Some suppliers simply bill for items never delivered; others bill carriers in States which pay high Medicare reimbursement, regardless of where the sale took place. In the last 3 years alone, over 80 convictions have been obtained in this area. We are pleased that the Department is currently undertaking reforms which will change point-of-sale rules and how provider numbers are issued.

Recently, we have seen abusive billing for body jackets, which help the patient sit up in a chair, and for lymphedema pumps. Lymphedema pumps are used to remove fluid from the extremities to reduce swelling. They are not for the general use of patients who have only regular edema and generally should not be used by patients with congestive heart failure. We have seen several cases of improper utilization and improper billing of these pumps. For example, a patient may be provided with a "non-gradient pressure pump" which would be reimbursed at $900, but Medicare was billed for a "gradient pressure pump" which is reimbursed at $4500.00. Because of the high reimbursement, the amount of potential fraud can rapidly reach $100,000.00 with only 20 or 30 claims.

Laboratory Fraud

We have encountered a number of schemes in the laboratory industry: (1) billing for services never rendered, (2) unauthorized or excessive tests, and (3) disguising billing procedures in which the carrier is actually billed twice. In the last 5 years, almost 50 convictions and civil actions have been obtained as a result of our laboratory investigations.

Hospital Credit Balances

The OIG has documented that the Medicare program loses millions of dollars because Medicare credit balances are not returned to the Government (about $266 million when we conducted our report). Credit balances occur because (1) Medicare is billed twice, (2) services are reimbursed by another insurer as well as Medicare and (3) services are billed but never rendered. While credit balances are an overpayment and monies should be recouped by the Government, in some instances we believe that fraud has been perpetrated. We are currently investigating certain facilities to determine whether criminal prosecution is warranted.

Patient and Program Protection Sanctions

The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health, and Block Grants to States for Social Services programs. Exclusions can now be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, and controlled substance abuse, as well as for revocation or surrender of a health care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse. During FY 1992, the OIG imposed 1,739 sanctions.

Civil Monetary Penalties for False Claims

Under the civil monetary penalty (CMP) authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false claims to the Medicare and State health care programs. The CMP law, therefore, allows recoupment of some of the monies lost through illegitimate claims, but it also protects health care providers by affording them due process rights similar to those available in the administrative sanction process. Many providers, however, elect to settle their cases prior to litigation. During FY 1992, the OIG recouped more than $28 million through 136 CMP settlements and hearing decisions.

National Health Laboratories Unbundling Case

As I have previously stated, there are no clear lines of distinction among the many types of fraud we investigate. As an example of a cross-cutting case involving laboratory fraud, kickbacks, and unbundling, I want to describe our recent investigation of National Health Laboratories, Inc. (NHL). The NHL is a major blood testing laboratory headquartered in California which pled guilty to submitting false claims to the Government and agreed to pay $110 million in a global civil settlement for defrauding Medicare by manipulating doctors into ordering medically unnecessary tests. The settlement is the largest ever reached between the Government and a health care provider in a health care fraud case. The agreement settles claims that NHL added high density lipoprotein cholesterol tests and iron storage (ferritin) tests to the series of blood tests doctors order most. This series of tests is most used because it is highly informative and relatively low-cost. By 1989, NHL was performing about 7 million of these tests a year. The two extra tests, however, were not really part of the series run, and were billed separately to Medicare regardless of whether the doctors had ordered them. Through NHL's scheme, the company knowingly submitted a large number of false claims. In 1988, NHL billed Medicare about $6000.00 for iron storage tests. By adding the test into the blood series and then unbundling the billing, NHL raised its reimbursement to $500,000.00 in 1989 alone. During a 3-year investigation, the OIG agents conducted interviews and investigatory activity throughout the country to determine the magnitude of the fraud.

Reforms Needed

As this Subcommittee is well aware, the OIG is also statutorily charged with promoting the economy and efficiency of the programs operated in HHS. For many years, we have been concerned about the efficiency of the Medicare and Medicaid programs in particular, as the costs have continued to escalate at the expense of the solvency of the trust funds.

As a result of these concerns, we have devoted a significant part of our office's resources toward analyzing the effectiveness of these programs and in identifying areas that have excessive waste. We are pleased that in the past the Congress and the Administration have enacted many of our recommendations which have improved the efficiency and effectiveness of our programs and have improved the solvency of the trust funds. As policy makers consider ways to reform the health care system, lessons drawn from the Medicare program and its vulnerability to fraud, waste, and abuse can be instructive. We believe that there are four overall categories of deficiencies in these programs which require further legislative or administrative modification: (1) some payments are excessive, (2) unnecessary and inappropriate care is rendered to beneficiaries, (3) financial conflicts of interest exist, and (4) Medicare systems are vulnerable to manipulation. Many of these areas merit further attention and corrective action. A listing of our significant unimplemented monetary recommendations can be found in our Cost-Savers Handbook, referred to as the Red Book. A listing of our significant unimplemented nonmonetary findings can be found in our Program and Management Improvement Recommendations referred to as the Orange Book.

In addition to recommendations contained in reports issued by our office, some options for correcting health care fraud and abuse vulnerabilities, which were advocated by a interagency task force (which included HHS and DOJ) to combat fraud and abuse, include:

- The current Medicare-Medicaid prohibition on kickbacks should be extended to all public and private payers.
- The current Medicare ban on payments for self-referrals should be expanded to additional services where the physician does not directly render the service and where abuses have been identified.
- The Medicare-Medicaid civil monetary penalty statutes and the Quality of Care sanctions should be strengthened to deter abuses.
- The routine waiver of Medicare Part B coinsurance except for low-income beneficiaries should be explicitly prohibited.
- Databases of all final adverse actions and certain active fraud investigations against health care practitioners should be established with appropriate safeguards for privacy and access.
- Standards to ensure accountability in the electronic media claims process should be developed. This should include provisions to ensure that (1) providers are held accountable for the accuracy, completeness, and truthfulness of claims submitted on their behalf, (2) the identity of the individual that caused the transmission of the claim is known, and (3) the patient is provided with information regarding the type of services for which reimbursement is claimed in order to be able to verify them.

Conclusion

The types of fraud that I have discussed in my testimony today could be avoided or lessened by closing loopholes that exist in the law or in Medicare rules and regulations. Hearings such as this help draw attention to these important problems that confront and weaken our health care delivery system. This concludes my prepared testimony.

Senator KOHL. Well, that's very good, Mr. Dyer. We appreciate your being here. I wanted to just go over with you this business of your staff, the amount of money we invest, the amount of money we get back, because we're talking about, potentially, a huge return to the taxpayer for what we invest. Now, you are one of how many offices across the country?

Mr. DYER. I am one. We have 9 separate regional offices. I cover 8 States myself, 13 offices in 8 States.

Senator KOHL. You have 13 offices in 8 States?

Mr. DYER. Correct.

Senator KOHL. And how many employees do you have under your direction?

Mr. DYER. Well, I have lost—since 1990, the Inspector General's office itself has lost 19 percent of its personnel, so we've had a one-fifth loss. I had started out with 60 something in personnel and got down to like 41. That loss has not been equal across the country. We've lost by attrition. In certain areas we've lost more. Our agents are highly trained. We have a large number of agents that have previous investigative experiences in other agencies. I come out of the FBI myself, I have former FBI agents, former Secret Service agents, former IRS agents, Postal investigative service, they bring the skills that they have learned in those agencies, they attend the Federal Law Enforcement Academy in Glenco, Georgia, they gain additional skills, they gain substantial expertise in dealing with the various insurance companies, the carriers, and they are in demand by other Federal agencies, frankly.

Senator KOHL. So you're in, did you say, eight States?

Mr. DYER. Yes, sir.

Senator KOHL. So in eight States the number of people with whom you work is down from 60 to 41?

Mr. DYER. That's correct.

Senator KOHL. And it is your contention, which apparently is documented——

Mr. DYER. Yes, sir.

Senator KOHL [continuing]. That for every dollar invested over an appropriate time, in terms of return on that dollar, it's $61 return to the taxpayer for every dollar invested in qualified personnel?

Mr. DYER. That's correct, sir, and that has consistently occurred over the years. It's consistently increased—actually it's gone down this year, I think, due to the loss of personnel. We return a great amount of money due to our civil suits. For instance, one company paid us $110 million. That's a substantial return. And I think those cases do take a substantial amount of time to develop and quite a bit of expertise to develop. I think we're really limited on our fraud investigations by our manpower alone. We have many more allegations that we are unable to address, frankly.

Senator KOHL. If you had sufficient personnel, do you believe that you could contribute greatly to the clean-up of this fraud and abuse that we have in our medical system?

Mr. DYER. Oh, I think we would make a major contribution, Senator, if we had additional personnel. We are very productive and very efficient in that process.

Senator KOHL. All right. Well, that's great. You've been very helpful to us this morning.

Mr. DYER. Thank you, sir.

Senator KOHL. Enjoy working with you.

Mr. DYER. Thank you.

Senator KOHL. Thank you for coming.

Our third and final panel this morning includes representatives from the insurance industry who also must deal head-on with the problems caused by health care fraud.

Mr. Tim Cullen is the President for Government Programs at Blue Cross-Blue Shield United of Wisconsin, which mainly deals with Medicare Part A. Many of us remember Tim Cullen from his long and distinguished service in the Wisconsin legislature, as well as Secretary of the State Department of Health. In both capacities, Mr. Cullen was very involved with many issues relating to seniors, especially health care.

And our second panelist this morning is Mr. Ned Boston, Director of Medicare Administration for Wisconsin Physician's Service Insurance Corporation, also known as WPS. Mr. Boston's insurance company deals mainly with Medicare Part B Medicare claims. Mr. Boston comes here from Madison today, and we thank you, Mr. Boston, for driving over to Racine this morning.

As with the other witnesses today, your written testimony has been received and will be entered without objection into the official hearing record. We would be delighted to listen to your summary and to have a chance to ask a couple questions.

Mr. Cullen.

STATEMENT OF TIM CULLEN, PRESIDENT FOR GOVERNMENT PROGRAMS, BLUE CROSS-BLUE SHIELD UNITED OF WISCONSIN

Mr. CULLEN. I thank you, Senator Kohl. Thank you for holding the hearing. No question much needs to be done. I think of all your responsibilities, if you only spent all of your time on this you'd be making a great contribution to this country. I'm going to try and touch on five areas as quickly as I can.

First is the area of fraud, and you heard the 10 percent number, whatever it is, it's a huge percent. In Medicare Part A, which is the hospital side of Medicare which we're responsible for in the division I lead, we are on the front line initial investigation of the fraud because we're the ones processing the claims.

A couple of examples of the fraud we see, one is that hospitals will bill Medicare for take-home drugs. That's against the law. They'll charge the hospital high price for drugs in the first place, give the people to take home and bill Medicare. And that's against the law.

Nursing homes.—Another example we see, nursing homes will charge the elderly what we call a waiting list fee, of $700 or so, to get on the list and have a chance to get into the nursing home. That's against the law to charge a senior citizen a dollar amount to get on the list and be on the waiting list for admission to a nursing home.

Cases that we have investigated, there are now four cases pending with the U.S. Attorney for possible fraud in Wisconsin, and also

as a Medicare party intermediary, we try to pursue providers for abusive billing practices. Sort of a lower level than fraud, but still it's billing Medicare for things that they should not have billed Medicare for. Thus far in 1993, we have recovered dollars from 112 different providers in Wisconsin and some of the other States where we process home health claims, of varying amounts of money, but from 112 health care providers.

The second area that I would want to touch on is what I would call foolish Federal spending priorities and regulations which, hopefully, you will have a chance to change.

In our division we have 280 employees, we process Medicare Part A in Wisconsin and home health claims in 34 other States. We will process 4.1 million claims this year, which will result in paying out $2.9 billion in benefits. And we do that with an overall budget of $17 million. For $17 million, we process all that and pay out $2.9 billion in taxpayer money. But of that sum, $17 million, we are only authorized to spend $274,000 on our investigation of fraud and abuse. So $274,000 out of the $17 million budget that ends up paying out $2.9 billion in claims. We are not asking for more money to process the claims. That's not my point at all. We have enough money to process the claims, but more dollars to help investigate fraud and abuse seems to be money well spent.

Now, a couple of technical matters which I think are things that you could have a chance to focus on. As I look at the Health Care Financing Administration, the part of H and H that's responsible for the Medicare and the Medicaid program, and on the Medicare side I see sort of two houses out there in Hickville, one side worried about the cost of contractors like us, how much we spent, those folks all responsible for how much money goes to pay contractors; and the whole other side of the house worried about how many dollars go out in claims, the big bucks, the billions that go out in benefits, and it's like the left hand and the right hand.

Now, even though a few more dollars spent on the contractors' side to investigate might result in billions or hundreds of millions less paid out because they'd catch the fraud, the two sides aren't looking at each other's budgets, they're not responsible for the other's performance. There's literally two sides to that house. And that's something I think is sort of an administrative change, so that those who are responsible for the contracting dollars have some responsibility for what goes out the door in dollars of claims.

The second thing, which is what Mr. Lehrmann touched on, which is why can't all the insurers work together to catch more fraud. We are prohibited by Federal regulations as the Medicare Part A intermediary from sharing our investigative findings with other insurers. In other words, as a Medicare party intermediary in Wisconsin, we can't share our findings with our private side, Blue Cross, we can't share them with WPS, or American Family, or Employers. We are prohibited by Federal regulation from doing that. We identify a lot of people who are abusing the system. We could share that with other insurers, it could help them to start targeting, start watching those providers more carefully. We can't do it because of Federal regulation.

The third point I'd make is there's really a lack, in my view, of a serious get-tough approach. For all that's been said here about

U.S. Attorneys and OIG and so on, lack of really concentrated effort to pursue recovery of dollars and convicting providers who defraud the Medicare system and the elderly. The way the system works is, we do a lot of the initial investigation, "we" being Medicare Part A intermediary. We find a lot of information. We turn it over to the OIG. They look at it. They decide whether they'll prosecute themselves on a civil basis or turn it over to the U.S. Attorney. Then they turn it over to the U.S. Attorney. Then it's the U.S. Attorney's job to make a judgment on priorities. Is this more important to look at than other things that the U.S. Attorney looks at.

And I'd be glad to share more of this information, the specifics, with your staff, but in summation, it seems to me like it lacks everything, this system. I mean it lacks speed, for sure, it lacks continuity, having different units of governments and private sector dealing with it, it lacks priority settings, and it certainly lacks effectiveness. And what's really missing when the whole system takes so long to get there is what I would call and others call the sentinel effect, that is, the providers knowing that somebody's watching, that somebody's taking it serious, and they're likely to get caught. If they see cases revolve through the system taking 1, 2, 3, 4, 5 years to reach a conclusion, that message, the message out there is, not a good chance of getting caught, and if I do, it's going to take a long time to get caught. A suggestion I would have for you would be to seriously consider maybe farming out to the private sector some of the prosecution, on a pilot basis, to see if—if you provide an incentive to the private sector, you pursue these cases, the only payment you get is a percent of the recoveries, a percent of what you get in dollars returned, see if they do even better than this dollars, the $61 ratio. Who knows? You do it on a pilot basis in a couple parts of the country and find out. But there the private sector would have a real initiative. They don't get paid unless they recover. Now that's real muscle, that's real incentive to go and recover.

Now, would the providers in the world like that system? I suspect not. I think they like the current system, if the truth be known.

I'll touch on a couple of other matters that are not related to Medicare Part A. One is Medicare supplement insurance. Most people who are over 65 have Medicare, because of some of the gaps in coverage they buy Medicare supplemental coverage. It's a major market for insurers. Our State law requires, in Wisconsin, that insurers that sell Medicare supplement insurance must return at least 65 cents of every dollar they collect in premium in benefits out to some policyholder who has their policy. That's the law—65 percent—it's called a loss ratio. It must be at least 65 percent. It must be at least 65 cents on every dollar. Yet, in Wisconsin, in 1991, 9 of the largest 20 sellers of Medicare supplement insurance paid out less than 65 percent, less than 65 cents on the dollar, contrary to Wisconsin law.

And my suggestion is the Wisconsin Insurance Commissioner make a much more serious effort to force these companies to comply or throw a few of them out of Wisconsin. That would be the message that I think might finally make a difference. But there's

no reason for companies, and I've looked at the numbers of some companies, lots of companies paying a lot more than 65 cents on a dollar, still in that business, still making money on it, want to stay in it, so the others could do it as well.

The last item is what I would call a category of lack of information. Senior citizens who have Medicaid coverage, many of them are in nursing homes, but senior citizens who have Medicaid coverage do not need any other insurance coverage, period. They don't need, particularly, a Medicare supplement policy. The law since 1991 has been that the insurers can't sell Medicare supplement coverage to people who are on Medicaid. But there are still thousands of people who still have their policies sold to them before 1991 or sold to them since 1991, in violation of the law, and it takes just badly needed dollars out of the pockets of our poorest citizens, those who qualify for Medicaid, if they're paying some of their limited dollars out to buy Medicare supplement insurance that they don't need when they have Medicaid. If they're worried about dropping their Medicare supplements policies and then becoming ineligible for Medicaid, there's a very easy way to handle that. They can suspend their Medicare supplement policy for up to 24 months, stop paying the premium for up to 24 months, and be entitled absolutely to automatic reinstatement anytime during that 24-month period. So they could suspend it, see if they're still on Medicaid, they've got 2 years to make a decision whether they're going to continue to be on Medicaid forever.

But it's something that, this kind of information, I think, that through your newsletter and other State and Federal officials who have the newsletter capability to share that kind of information is the way I think best to get that word out on a variety of, I guess, of other vehicles that would be available.

But I would conclude by saying these abusive problems were not created overnight, you're not going to solve them overnight, but if you do take the time and energy, as you are today, and I particularly say, from having some experience on the Government side, that if the bureaucracy and those who are responsible for this bureaucracy, those of us who are the intermediaries, if you and your staff stay on it year in, year out—the bureaucracy tends to believe that elected officials come and go, as I think you're aware, and I think, and I've been on both sides, I've been on the bureaucracy side, too—if they know that you and your staff are not leaving this stuff and you stay with it for a few years, you can make a great difference, and I know you want to, and I'll be doing my part to make sure that you do have a chance to do that for several years. Thank you very much for holding the hearing.

Senator KOHL. Thank you very much, Tim. It was great testimony. I'd like to get back to you in a minute with some questions.

Mr. Boston.

STATEMENT OF NED BOSTON, DIRECTOR, MEDICARE ADMINISTRATION, WISCONSIN PHYSICIANS SERVICE INSURANCE CORP.

Mr. BOSTON. Good morning, Senator Kohl. I'm here this morning representing the Medicare Part B carrier in the State of Wisconsin, WPS Insurance.

We have 300 employees in Madison processing over 10 million claims this year. In the last Federal fiscal year we disbursed $497 million in benefits on behalf of Wisconsin Medicare beneficiaries. If the number we've heard several times today, the 10 percent of those benefits, are fraudulent or abusive billing practices, then in Wisconsin, in 1992, for just physicians and suppliers, over $50 million was inappropriate expenditure of public funds.

We take it as a very serious carrier responsibility to try to safeguard those funds through detection of abusive situations, and it's important to note that not all of inappropriate expenditures are out-and-out fraud. There are many different types of situations that need to be addressed to bring the entire expenditure situation under control.

The most severe form of abuse we see is simply out-and-out fraud, i.e., billing for services that were simply never rendered. We have spent several years working with the Office of Inspector General, for example, on a provider in Southern Wisconsin whom we've suspected of billing for tests and other services that were not rendered. One of the allegations is that this provider took samples of drugs provided free from drug companies, repackaged them, and sold them to beneficiaries. It's taken us a good many years to get that case along, and that ties in with what Mr. Cullen addressed and the time it takes sometimes for us to do it. But the important thing is both the Office of Inspector General and the carrier have worked together to try to detect and resolve that situation.

Another situation that we find very disconcerting is where a provider bills a beneficiary for far more than they're legally entitled to charge. Congress, in the Omnibus Reconciliation Act of 1989, placed very specific limits on what nonparticipating Medicare physicians may charge beneficiaries. Unfortunately, that law is a toothless tiger. The current law lacks the statutory authority for us to require that physicians who overcharge return that money to beneficiaries.

We were somewhat distressed to learn that in the Reconciliation Act that just passed, language that would have allowed or given us the authority to demand that those refunds be made was, in fact, pulled at the last minute.

Let me give you an idea of the nature of this problem in Wisconsin. Since the first of the year, we've had approximately 300 situations where we've detected that a physician has overcharged the beneficiary in excess of $500. We have no authority at this point to require that physician to refund that money, and we consider that abusive.

Yet another situation that we encounter is where a Medicare provider bills a service that is a more expensive service than what was actually rendered, and this is not very difficult to do given the volumes and the kinds of situations that we all see in the insurance industry.

For example, what we're working on now in one case is a situation where we cover, in the ambulance transportation section, advanced life support and basic life support services. Obviously, we anticipate that the provider will render the least costly service necessary commensurate with the needs of the patient. But in some cases we find that the more expensive service is billed. If in fact

an ambulance provider were to bill an advanced life support service instead of a basic life support service, the Medicare program would pay approximately $130 more for that individual service. But just as important, the beneficiary would owe an additional $30 for the increased coinsurance, and that is money that should not be spent.

Still another practice we find is where a provider, accidentally or intentionally, misrepresents a service delivered through an incorrect coding. We have received several hints in the past and have investigated the situation where, particularly in DME, durable medical equipment, where devices that we thought we understood what we were reimbursing turned out to be something very different. Recently we discovered a prosthetic device that was being billed to us as a back brace that, in fact, turned out to be a comfort and convenience item for wheelchair patients. We're not saying that it wasn't useful. It simply is not covered under the Medicare program.

Finally, many times the abuse that we see takes the form of providing items or service that are truly not necessary. Most of the time these services do not harm the beneficiary, but neither do they help and they cause a great deal of expenditure.

We are seeking a repayment of over $400,000 from one Wisconsin provider who, in our estimation, administered tests that were not medically necessary. That provider is, as you might expect, contesting our findings, and we will carry that through the hearing process to conclusion.

We have also found that we have paid for what we believe is an abnormally high number of irrigation and cleansing kits for gastrostomy tubes, that's an artificial feeding tube opening. Our carrier medical director believes that these kits are of little value and, at the outside, would be used once a week. Yet, in 1 month we paid for 1,005 sets of these kits on behalf of 49 beneficiaries. Now, that's not an item that's going to harm the beneficiary, but we are now reviewing our policy and we will seek re-collection where we can of those. We averaged $29 for each of those sets.

Safeguarding Medicare expenditures requires resources to detect abusive situations and then resources to enforce Medicare law and regulation. Both must work hand in hand. As a carrier, we have the responsibility to administer a series of computer programs to detect what we consider abusive situations. We then, as does Mr. Cullen, work with the Office of Inspector General and U.S. Attorney's office when we find the most blatant types of situations.

The Health Care Financing Administration has greatly expanded its expectation of contractors to detect fraudulent and abusive situations. I must, however, caution that in the past years the funding for these kinds of activities has been like a roller coaster at Great America. We've added staff, we've reduced staff, we've added staff, we've reduced staff. We need to have some sort of continuity to that funding so that we can do our part with that picture. Adequate funding for those activities is imperative to maintain control over these constantly increasing expenditures.

Senator I appreciate the opportunity to address you this morning, and I would be delighted to answer any questions that you may have.

Senator KOHL. All right. Well, I think that we have two experienced people, very expert in the whole business of medical care in our country, and we're going to reform the system or try and reform the system.

I would like to ask you to comment with respect to this business of getting efficiency into the system, weeding out unnecessary costs, eliminating as much waste and fraud and abuse as possible.

Just visualizing at least what appears to be the system that's emerging from the President's Task Force which, as you know, is to set up large consumer groups who will then bargain with private industry based on a package, a standard benefit package, you know what we're talking about here, do you think that this system that they're talking about will really do something significant to reduce the amount of waste that now presently exists in American health care delivery? What do you think, Mr. Cullen?

Mr. CULLEN. Well, I think that the presumption that they're going to have lots of different hospitals and clinics and so on to negotiate with, you know, and therefore they can negotiate, play them off against each other and get the best price. I think that's going to be a fallacy in many parts of the country. What we're seeing in Wisconsin is massive numbers of mergers going on, so that there's going to be largely one corporation controlling the health care in different regions of this State. Aurora from Sheboygan to Kenosha is quickly moving. I'm not criticizing them for doing it. I think it is a good business decision on their part. They're largely moving to control health care in this region. And then you've got Marshfield and Gundersen at Mayville, and then Mercy Hospital in Janesville, and so on. They're buying and buying and buying and buying so that the presumption that these regional purchasing councils, whatever you want to call them, whatever they're going to be called, they're going to be able to negotiate with one entity. And that's what's going on at least in this State. I don't know about the rest of the country. But the concept of giving consumers the power, collective power, that they don't have individually. If WPS, if they had 70 percent of the market share in this State, we wouldn't be very happy; or if we had 70 percent of the market share in this State, WPS wouldn't be very happy. But if one insurer had a substantial market share, they always point to—Rochester, NY, has a great example. Well, it's because Blue Cross is 70 percent of the market there. If we had one insurer who had the clout to go in and demand discounts, we might be able to get some savings that way; but none of us have—we both have about 10 percent of the market share, and that's the most in Wisconsin. So because the insurers don't have the clout because they don't have the market share, consumers haven't had that benefit. So the idea that these councils would have some consumer clout makes sense, but only if there's more than one entity out there to negotiate with. And that's my concern as I look at what is going on in Wisconsin.

Senator KOHL. Thank you.

Mr. CULLEN. It has not much to do with fraud and abuse as I see it. I don't know if that's really been a focus from what I've seen of what's coming from Washington, but there I think it's just a matter of the providers being scared to death that somebody's real-

ly going to come and get them and catch them, and I think that sentinel effect of that fear is missing today.

Senator KOHL. Do you believe that there is an enormous amount of unnecessary expenditure going on in the health care system?

Mr. CULLEN. There's no question about it. And it goes back to us largely, all of us, and I mean me and probably almost anybody in this room, unless they're a doctor. When we go to a provider, we want to get well, and we don't know a darn thing about what's going to make us well. That provider does. So they say, you need three tests, Mr. Cullen, to see if we can find this thing. Can I say no, I think I only need two? I don't. I say, get me well. Give me the three tests. If I walked into a TV store and the guy tried to sell me three TV sets, I'd say no, I want one TV set. Don't try to snooker me into three. But we don't know anything about health care, so we need a purchasing method or some method of helping us have some collective clout. We don't know what we're buying, probably more so than anything else we buy. We never ask price.

How many people walk in and say, Doctor, okay, I'll have that test, but how much is it going to cost me? Is it cheaper down the street? We don't ask those questions and so there's a real presumption in our, I think, our psyche that the provider's only going to give what you say we need.

Well, when it was just us and the doctor—and I think doctors do a great job in this country—the doctor/patient relationship in my view, I've grown more committed to it and understand that we can't be messing around with that relationship; but once you get to larger clinics and all the billing costs are not in the doctor's hands and nursing hands, this is all done by staff and you've got staff under pressure to maximize revenue for the clinic, maximize revenue for the hospital. So that stuff was all taken out of the doctor/patient relationship and it's done by somebody else. It's always somebody else did it. Billing departments. Providers spend money teaching their staff how to maximize the billing practices against insurers like all of us insurers. Then we go hire a bunch of staff to figure out how to catch them, and in that process is an enormous amount of waste and cost in the health care system that's unnecessary. I ramble a little bit, but it's something that gets to me.

Senator KOHL. No, that's very important. Mr. Boston, I would like to hear what you've got to say.

Mr. BOSTON. Senator, I haven't seen anything in the plans that I've seen from Washington that would structurally cure some of the kind of situations I described. No matter the size of the provider of medical service or the size of the payor, if that provider decides to do, as Mr. Cullen addressed, additional tests, or provide things that truly aren't necessary but enhance revenue to the provider, those types of situations can happen in large or in small situations. So I don't see structurally that we've solved any problem, yet, without a very coherent program of detection and prosecution of when we find these kinds of situations, be it a large pool or a small.

Another issue that we haven't addressed is what has happened as the Government programs have become better at addressing these fraud and abuse situations. We certainly at WPS, and I'm sure Mr. Cullen has seen where some of these costs have been transferred over to our private sides, making insurance more ex-

pensive on the private side. We simply haven't addressed the total spectrum of delivery and payors to bring it together into some sort of a unified structure with cooperative sharing. We're not allowed to share with Mr. Cullen information. He's not allowed to share with us. So what I say might look to us as if I have a thousand dollars situation, might look to him as if I have $10,000. If it was $10,000, we'd be more interested. So without that kind of sharing——

Senator KOHL. All right. Let me just ask you one more question. As you see this whole thing beginning to emerge, and it's distant and I know that it's hard to render any kind of preliminary opinions in terms of what we're trying to do, which is, as you know, control the cost, maintain the quality, expand the coverage, are you excited, encouraged, concerned, don't have an opinion, discouraged? Give us your expert opinion at this early, early date that, you know, as you see this thing now just beginning to unfold. What kind of thoughts do you have, just briefly? I would be interested in hearing. Just briefly. Do you think we're headed in the right direction?

Mr. CULLEN. You have to do something. Bigger thing to do, the better, in my view. I think that it's going to take you 10 years to get it done, and there's two sides to it; there's the coverage side, getting people covered, and then doing something about costs. In my view, you can do the coverage side quicker. Might take a couple of gutsy votes to do it, but if we are going to have an employer-based coverage system or not, we get our insurance from the place that we work. That's with Medicare or Medicaid, whatever. So either we scrap the employer-based system or the employer has to offer coverage.

Senator KOHL. But if you do the coverage side first, then we're going to magnify the costs; right?

Mr. CULLEN. Well, that depends. I mean you don't have to magnify the costs. There's supposedly a lot of charity care that's now being—it isn't charity care, it's in the premiums of those who do have coverage. So if you cover the people that are being covered, hard to believe that the charity care would be developed to zero, so you would have to assume that there's more dollars being expended, but you have to get them in the emergency room, big dollar costs. It's hard to really put a dollar sign on that.

But getting the coverage side down is the most important element, I think, in the whole thing, and the cost side is tougher, and when you've got a $900 billion industry, nobody wants to give up a dime. But I think you have to do it. I'm excited about it. I hope that this deficit bill, which I'm also happy, proud of you for voting for, I hope that that thing—you're going to need bipartisan support from now on, I wish that you could have had it there—but you've got to do it, and I think that this 2-year session of Congress and this 4-year Presidency may well be judged on how far you get in health care as much as on the deficit reduction.

Senator KOHL. Thank you.

Mr. Boston.

Mr. BOSTON. Senator, I have over 20 years of experience in the Medicare and Medicaid program, probably the two largest health care programs in the country, so I've seen what it takes to admin-

ister a very large scale program; and yet, those programs pale to what is being suggested. I am certainly excited about the changes that we are going to see and the kinds of opportunities, but I'm reminded that a camel is a horse that is designed by a committee, and I'm concerned that the structure that comes out of this be something that can be administered, or we can sink very, very quickly. When we deal in the very, very large volumes that we're discussing, careful design of a structure that makes sense administratively could be the difference whether it works or not.

Senator KOHL. Thank you.

Mr. CULLEN. National structure with a State-by-State administration. I mean even Canada is a Province-by-Province system, so I think you need national guidelines and national structure, coverage and benefit levels, and so on, but I don't think you want to ever try to administer it regionally or nationally. You have to get it out to the State level.

Senator KOHL. Thank you. Well, thanks very much, guys. You've been very helpful.

Mr. CULLEN. Thank you.

Mr. BOSTON. Thank you.

Senator KOHL. I appreciate very much your coming.

Now, as we close what I think has been a very good hearing, I, myself have learned an awful lot, and I think that we have exposed now, and I hope it will emanate out to the people in Wisconsin, some very serious problems, magnify them, put the microscope on them, and I think that we will all benefit from having taken the time to put together this hearing.

Before I close, I would like to thank Jim Schneider from the Gateway Technical Institute, and our court reporter, Dave Wahlberg, and, of course, our sign language interpreter, Beverly Rappold. We thank you very much.

[Whereupon, at 11:27 a.m., the Committee adjourned, to reconvene at the call of the Chair.]

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